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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation on May 25, 2022 - May 26, 2022.	D 000		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to provide personal care according to the care plan and assessed needs for 1 of 4 residents sampled (#4) related to incontinence care. The findings are: Review of Resident #4's current FL-2 dated 02/14/22 revealed: -Diagnoses included type 2 diabetes, meningitis, and hypertension (high blood pressure). -She was constantly disoriented. -She required personal care assistance with bathing and dressing. -She was incontinent of bowel and continent of bladder. Review of Resident #4's Care Plan dated 02/13/22 revealed: -She had wandering behaviors.	D 269		

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-She was ambulatory with no problems or assistive devices.
-She had daily incontinence of bowel and bladder.
-She was always disoriented and forgetful, needing reminders.
-She required limited assistance for toileting, bathing, dressing, and grooming.

Observation of Resident #4 on 05/25/22 at 8:30am revealed:
-She was ambulating down the 300 hallway with three health and occupational wellness students to her room at 8:30am.
-Her gown was saturated through with urine and there was a strong urine smell.
-The personal care aide (PCA) for the 300 hallway told Resident #4 to go with the students to get changed for breakfast.

Observation of Resident #4 on 05/25/22 at 8:52am revealed Resident #4 ambulated independently from her room to the dining room and ate breakfast after being changed by the students.

Observation of Resident #4 on 05/25/22 from 9:15am to 11:30am revealed:
-She stayed seated on a sofa in the common area television room.
-Incontinence care was not performed by any staff members during that time.

Observation of Resident #4 on 05/25/22 from 1:00pm to 3:00pm revealed:
-She ambulated from the dining room to the front doorway and sat in a chair at the front door.
-Her pants were saturated with urine.
-No incontinence care was performed during that time until a survey team member brought it to the PCA's attention that she was saturated.

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D 269	Continued From page 2 Observation of Resident #4 on 05/26/22 from 9:15am until 11:15am revealed: -Resident #4 stayed seated on a sofa in the common area television room. -Incontinence care was not performed by any staff members during that time. -She was saturated through her pants and staff took her to her room to change clothes. Interview with a PCA on 05/25/22 at 1:25pm revealed: -Over 50% of the time, when she starts her shift in the morning Resident #4's clothing and incontinence brief are saturated with urine. -It was the expectation that staff perform incontinence care at least every two hours or more frequently if needed. -She was aware that Resident #4 was frequently incontinent of urine so she would check on her hourly. -Resident #4 did not have any skin breakdown. -It was difficult to provide residents incontinence care when there were only 2 PCAs on shift. Interview with a second PCA on 05/26/22 at 2:05pm revealed: -She checked on residents that she knew were frequently incontinent every 20 minutes. -Over 50% of the time, when she starts her shift in the morning Resident #4's clothing and incontinence brief are saturated with urine. -It was not documented when she performed incontinence care on residents. Interview with the staff member responsible for laundry services on 05/25/22 at 3:30pm revealed she usually did Resident #4's laundry daily, during the week because her clothes were usually saturated with urine.	D 269		

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D 269	Continued From page 3 Interview with the Resident Care Coordinator (RCC) on 05/26/22 at 1:05pm revealed: -She expected residents that required incontinence care to be checked on at least every 2 hours of if visibly soiled. -She expected Resident #4 to be rounded on hourly by staff because she was known to be incontinent frequently. -She was not aware that staff were not performing incontinence care at least every two hours on Resident #4. Interview with the Administrator on 05/26/22 at 2:47pm revealed: -She expected incontinence care to be performed every 2-3 hours. -She was not aware that Resident #4 was not being offered incontinence care at least every 2 hours. Telephone interview with Resident #4's primary care provider (PCP) on 05/26/22 at 4:00pm revealed: -She expected staff to perform incontinence care at least every 2 hours during the day to prevent discomfort and prevent skin breakdown. -She was told by Resident #4 that when they came to visit the resident she was frequently saturated through the incontinence brief and her clothing. Attempted telephone interview with Resident #4's family member on 05/25/22 at 2:50pm and 05/26/22 at 9:20am were unsuccessful. Based on observations and interviews, it was determined that Resident #4 was not interviewable.	D 269		

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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 A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up for 4 of 5 sampled residents (#1, #2, #3, and #5) in which residents' primary care providers (PCP) were not notified that medications were unavailable upon admission to the facility for administration as ordered (#1, #3, #5), referral appointments were not scheduled as ordered by the residents' PCP (#3, #5), and finger stick blood sugar (FSBS) results outside of ordered parameters were not reported (#2). The findings are: Review of the facility's Accommodations and Services Assisted Living Resident Agreement dated 05/23/16 revealed: -Residents were to receive services described in their Resident Service Plan to include care checks, assistance with activities of daily living, general observation and supervision, and medication assistance. -Residents were to receive third party services such as pharmacy medication delivery and medication management services from the facility. -The facility was responsible to order all medications and have the necessary supply of	D 273		

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medication available.
-The facility was to notify the resident's primary care provider (PCP) of any missed doses of medication.
-Residents had the right to receive care and services which were adequate, appropriate, and in compliance with Federal and State laws, rules, and regulations.
-Residents were to be free of mental and physical abuse, neglect, and exploitation.

1. Review of Resident #5's current FL-2 dated 12/30/19 revealed:
-Diagnoses included type 2 diabetes mellitus (DM), acute encephalopathy, anoxic brain injury, and a history of acute respiratory failure.
-The resident was ambulatory and intermittently disoriented.
-There was an order for Lantus 32 units (long acting insulin medication to stabilize blood glucose levels) at bedtime.
-There was an order for Humalog 100u/ml 5 units (short acting insulin used to lower blood glucose levels) every morning with breakfast.
-There was an order for Humalog 100u/ml 2 units daily with lunch.
-There was an order for Humalog 100u/ml 5 units daily with supper.
-There was an order for Metformin 500mg (an oral medication used to lower blood glucose levels) twice daily with meals.
-There was no order to obtain FSBS.

Review of Resident #5's Resident Register dated 01/02/20 revealed the resident was admitted to the facility from the hospital on 01/02/20.

Review of Resident #5's resident assessment tool dated 12/31/19 revealed:
-The resident was to take 11 daily medications.

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-He required extensive assistance with bathing, personal hygiene, dressing tasks, transfers, toileting, and eating.

Review of Resident #5's vital sign report dated 01/02/20 through 01/05/20 revealed:
-The resident arrived at the facility for admission on 01/02/20 at 8:47am.
-There was a weight documented on 01/02/20 at 5:54pm.
-The resident had a blood pressure of 114/57, a heart rate of 82, and a temperature of 98.1 F documented on 01/05/20 10:24am.
-There was no FSBS documented for the resident.

Review of Resident #5's progress notes revealed:
-On 01/03/20 at 6:30pm, it was documented that the facility's contracted pharmacy was contacted to follow up on when the resident's medications were to be delivered due to the resident needing his insulin and being non-compliant with his dietary restrictions; it was too late to request back-up medications from the pharmacy; the responsible party and primary care provider (PCP) were notified.
-On 01/03/20 at 8:46pm, the resident was sent to the Emergency Room (ER) due to a high FSBS reading.
-On 01/04/20 at 2:25am, the resident returned from the ER and the resident was to follow-up with his PCP on 01/08/20.
-On 01/04/20 at 5:02pm, the resident's FSBS was 555 mg/dl (normal FSBS ranges for a person with DM is 80-130 mg/dl); he was given 5 units of Humalog at that time.
-On 01/04/20 at 10:16pm, the resident's FSBS was retaken and was 545 mg/dl.
-On 01/05/20 at 10:25am, the resident fell in his bedroom doorway, vital signs were obtained, a

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FSBS was obtained twice, both FSBS results read HI (too high to calculate on the glucometer machine), notification sent to the PCP and responsible party and the resident was sent to the ER where he was admitted for care.
-There was no documentation that the resident's PCP was notified that he did not have medications available for administration on 01/02/20-01/03/20 or that he did not have an order to receive FSBS.

Review of Resident #5's Incident/Accident (I/A) report dated 01/05/20 revealed:
-The resident had a witnessed fall in the middle of his bedroom doorway.
-The resident stated his "legs gave away" and he was trying to sit up.
-The resident did not have injury or pain but was sent to the ER due to high FSBS where he was admitted and diagnosed with diabetic ketoacidosis (DKA) (a serious complication of diabetes that occurs when there is not enough insulin in the body and produces excess blood acids (ketones) that requires emergency care that could lead to diabetic coma or death).

Review of Resident #5's hospital History and Physical (H&P) dated 01/05/20 revealed:
-The resident presented to the ER with a history of poorly controlled DM with elevated FSBS along with polyuria (excessive urination), polydipsia (excessive thirst), and nausea.
-His blood gases indicated uncompensated metabolic acidosis (a serious electrolyte disorder that could result in impaired kidney function, cardiovascular health, or death).
-The resident was diagnosed with DKA and acute kidney injury and required intravenous insulin and electrolyte and fluid rehydration.
-The resident was directly admitted to the

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intensive care unit (ICU) for further care after stabilization.

Review of Resident #5's hospital progress note dated 01/11/20 and 01/16/20 revealed:
-The resident was improving with care and aggressive insulin medication management.
-The resident was unable to care for himself due to a history of brain injury and was awaiting a bed placement in a nursing home.

Review of Resident #5's hospital discharge summary dated 01/17/20 revealed:
-The resident was improving and required aggressive medication management.
-The resident was discharged in stable condition to a skilled nursing facility (increased level of care from assisted living) to continue therapy for further care.

Interview with Resident #5's family member on 05/25/22 at 4:08pm revealed:
-Resident #5 was admitted to the facility on 01/02/20 and was not oriented and unable to make decisions or care for himself.
-Resident #5 did not have any medications on hand at the facility when he was admitted to the facility from the hospital on 01/02/20.
-Due to Resident #5 not having his medications for two days, his blood sugars rose to dangerous levels and he was admitted to the hospital in the intensive care unit (ICU).
-She went to the facility to be with Resident #5 the afternoon and evening he was admitted on 01/02/20 to finish signing his admission paperwork and it was difficult to get staff's attention that night and have staff help him with the care he needed.
-She was not made aware on the day of Resident #5's admission to the facility that he did not have

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his medications on hand as needed and the facility staff did not ask her to assist in obtaining the medications.
-She received a call later than night after she left on 01/02/20, that the Resident #5's blood sugar was high, and the facility was sending him to the hospital to address the issue.
-Resident #5's diagnosis of diabetes mellitus and his need for insulin was not new for him and should have been addressed immediately upon his admission.
-A few days later, Resident #5 fell in his doorway and was sent back to the hospital because his FSBS was high again and that was when he was admitted to the ICU.
-The facility neglected to provide Resident #5 his insulin and other medications as ordered and that was why he became so sick and eventually needed a higher level of care.
-She was not sure if Resident #5's PCP had been contacted or if the facility tried to obtain his medications in a timely manner at all.

Interview with an order entry technician at the facility's contracted pharmacy on 05/25/22 at 1:50pm revealed:
-The pharmacy received Resident #5's admission medication orders via fax from the facility on 01/03/20 at 12:29pm (on the second day of admission); the pharmacy had not received any medication orders from the facility prior to that date.
-The pharmacy immediately entered Resident #5's orders into his profile in the computer system and filled the medications to be sent to the pharmacy.
-Resident #5's medications were sent to the facility on 01/03/20 at were received at the facility on 01/04/20 at 1:56am.
-The facility did not request the medications to be

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filled STAT (immediately), but if the facility had requested the order to be filled STAT, the pharmacy would have had the medications to the facility within four hours or less of the time they received the orders from the facility.

Interview with the medical records representative at the facility's contracted primary care provider's (PCP's) office on 05/25/22 at 2:25pm revealed there was no documentation that the facility notified Resident #5's PCP of not being able to obtain his medications upon admission or having high FSBS.

Interview with a medication aide (MA) on 05/25/22 at 2:25pm revealed:
-She had worked at the facility during the time Resident #5 was admitted to the facility on 01/02/20 but did not recall being involved in Resident #5's admission.
-It was the facility's policy to ensure a resident's medications were available for administration as ordered upon admission or shortly thereafter within four hours of faxing the orders to the pharmacy.
-If a resident was admitted to the facility with a diagnosis of diabetes mellitus and did not have insulin on hand to be administered as ordered, it was the MA's or the Resident Care Coordinator's (RCC's) responsibility to contact the resident's PCP and the contracted pharmacy immediately to notify them and attempt the remedy the issue.
-Residents were not to go longer than four hours without having medications administered to them as ordered and the facility should have requested Resident #5's medications from the pharmacy STAT.
-If Resident #5 was missing an order to monitor FSBS for his DM diagnoses and administration of insulin, it was the MA's or RCC's responsibility to

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call the resident's PCP immediately for clarification to obtain an order to care for the resident safely.
-If the facility had notified Resident #5's PCP or pharmacy of being unable to obtain his medications to be administered as ordered, it would have been documented in the resident's progress notes in his record.
-She was not sure why the facility failed to call the Resident #5's PCP or pharmacy when unable to obtain his medications, but it was a failure in the facility's expected process.

Interview with the RCC on 05/25/22 at 2:55pm revealed:
-She did not work at the facility when Resident #5 was admitted to the facility on 01/02/20.
-The Administrator was responsible to ensure the facility had an accurate FL-2 with orders and a history and physical for a resident who was to be admitted prior to admission.
-It was her or the MA's responsibility to immediately fax medication orders to the pharmacy upon a resident's admission to ensure medications were on-hand to be administered as ordered.
-The pharmacy normally delivered requested medication to the facility within 24-hours, but the facility was responsible to request STAT processing (within 4 hours) for new admissions to ensure medications were on hand in a timely manner.
-It was unacceptable for a diabetic resident to go longer than one day without medication because their medications were ordered to treat their health needs and the resident's FSBS could go too high.
-The RCC or the MA should have called the pharmacy and the Resident #5's PCP for orders and guidance of care if they could not obtain his

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medications within four hours of admission.
-If the facility had called the pharmacy or the PCP, the conversation would have been documented in Resident #5's progress notes; she was not sure why the facility faxed the orders a day after admission and did not call the pharmacy or the PCP to expedite getting Resident #5's medications on-hand for administration as ordered in a timely manner.
-The RCC or the MA also should have called Resident #5's PCP to obtain/clarify orders for FSBS since he did not have orders to do so and was diagnosed with diabetes mellitus.
-The RCC or the MA were also responsible to call Resident #5's PCP when they did obtain FSBS without an order and had readings that were elevated or too high to be read on his FSBS machine for guidance of care.
-She was not sure why Resident #5's PCP was not called regarding the elevated FSBS and delayed medications, but that led to a delay in care and adverse outcomes.

Interview with the Administrator on 05/25/22 at 3:33pm revealed:
-She did not work at the facility when Resident #5 was admitted on 01/02/20.
-If Resident #5 had not arrived with any medications on-hand, it was the facility's responsibility to procure the medications he needed and were ordered to ensure safe care.
-It would have been the RCC or MA's responsibility to immediately fax Resident #5's orders to the pharmacy upon arrival to the facility and have them processed STAT to be administered as soon as possible as ordered.
-Resident #5 should have never missed any doses of his medications because the facility should have coordinated how medications would be on hand for administration as ordered prior to

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his admission.
-Residents who miss doses of medications could have adverse health issues or even death related to the diagnoses the medication had been prescribed for by his/her PCP.
-The MAs or the RCC were responsible to verify they would be able to meet the needs of the resident prior to admission and anyone at the facility would have been responsible to call the pharmacy and Resident #5's PCP when they were unable to obtain and were unable to administer his medications as ordered.
-Any communication with the pharmacy or Resident #5's PCP would have been documented in his progress notes in his records if it has been done.
-She was not sure why Resident #5's PCP had not been notified that his medications were unavailable, that he was having high FSBS, or that he had been sent to the hospital, but they should have notified his PCP so they could guide his care and prevent a bad outcome.

Interview with a pharmacist at the facility's contracted pharmacy on 05/25/22 at 2:01pm revealed:
-It was the facility's responsibility to fax a resident's medication orders to the pharmacy immediately or as soon as possible upon receipt or the resident's arrival to the facility as a new admission and to contact the resident's PCP if there were any issues or concerns regarding a resident's medications.
-The pharmacy would enter new medication orders into the resident's profile in the computer system and fill the medications to be delivered to the pharmacy within the same business day or the next business day of receiving the orders.
-It was the facility's responsibility to notify the pharmacy if medication orders need to be filled

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STAT, meaning they need it as soon as possible or within four hours of faxing the orders.
-If the facility had faxed Resident #5's orders on the day of his admission and notified the pharmacy they needed his medications STAT, the pharmacy would have ensure the facility received Resident #5's medications within four hours and would have worked with a back-up pharmacy to ensure the medications were received within four hours if the pharmacy was unable to provide the medications as expected.
-If a diabetic resident was to go without insulin longer than four hours of it being needed, it could cause the resident to have increased blood sugars which could lead to a multitude of issues to include diabetic ketoacidosis.
-The pharmacy was available to the facility 24 hours per day 7 days per week and the pharmacy did not know how to best assist if the facility did not communicate appropriately for resident needs.

Interview with the facility's contracted primary care provider on 05/25/22 at 11:05am revealed:
-She expected the facility to have accurate and complete orders for all residents.
-If the facility was missing an order, or an order is unclear, she expected the facility to call her to clarify what care she wanted provided to a resident.
-She expected medications to be administered accurately as ordered.
-It was the facility's responsibility and priority to ensure a resident's medications were available on hand upon admission or as soon as possible there after not exceeding four hours post-admission.
-She expected to be notified immediately if the facility was unable to obtain the medications a resident needed within four hours of admission.

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D 273	Continued From page 15 -It was important to notify a resident's provider if medications were unavailable because the provider was often able to help troubleshoot and contact the pharmacy to have the order expedited or work with another back-up pharmacy to ensure the medications were available within a safe time-frame. -If Resident #5 did not have FSBS orders with parameters or insulin on hand, she would have expected the facility to call her so she could provide orders and guide his care. -If Resident #5's FSBS were elevated, she would have evaluated why and would have provided orders for him to have insulin. -She would have expected to be notified of Resident #5's elevated blood sugars over 400-500mg/dl or a blood sugar that was "unreadable" as "HI" immediately. -It was inappropriate for the facility to not administer Resident #5's insulin and other medications for 48 hours post-admission and they should have called for an order to monitor the resident's FSBS closely. -The facility might have been able prevent the resident's need to be admitted to the hospital in the ICU for diabetic ketoacidosis if they had accurate orders and administered his insulin as ordered. -It did not take long for a resident with diabetes to have blood sugars that were uncontrollable when they go without their insulin for more than one dose. -Resident #5 missing his insulin for 48 hours caused him to go into diabetic ketoacidosis and the provider responsible for him at that time should have been notified to intervene and guide his care for his safety. Interview with another one of the facilty's contracted PCPs on 05/26/22 at 4:00pm	D 273		

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revealed:
-She expected to be notified if a resident's medications were unavailable for administration as ordered.
-Residents should never miss more than one dose of a medication because missing medications could cause a resident harm.
-It was especially important to have known that a resident missed doses of insulin because she would have provided orders for closer monitoring due to the side effect of missing the dose.
-Missing doses of insulin could have led to increased blood sugars, altered mental status, dizziness, confusion, kidney failure, coma, and a trip to the emergency room (ER).
-If she had been made aware, she would have gotten involved and assisted the facility in obtaining the medications in a timely manner by contacting the pharmacy and requesting a STAT order.
-Resident #5 missing his medications as ordered was definitely a contributing factor to his fall and having to be admitted to the hospital.
-If that facility had administered his medications as ordered could have prevented his outcome of needing to be hospitalized and possibly his need for an increased level of care.

2. Review of Resident #3's current FL-2 dated 04/05/22 revealed diagnoses included chronic pulmonary obstructive disease, vitamin D deficiency, insomnia, atherosclerotic heart disease, hyperlipidemia, anxiety, hypertension, coronary atherosclerosis, and stage 4 chronic kidney disease.

a. Review of Resident #3's current FL-2 dated 04/05/22 revealed:
-There was an order for Ascorbic Acid 500mg daily (Ascorbic Acid is a medication used for

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Vitamin C replacement).
-There was an order for Aspirin 81mg daily (Aspirin is a medication used to treat pain and inflammation).
-There was an order for Atorvastatin 40mg at bedtime (Atorvastatin is a medication used to treat high cholesterol).
-There was an order for Calcitriol 0.25mcg daily (Calcitriol is a form of vitamin D used to treat patients with chronic kidney disease).
-There was an order for Flonase 50mcg in each nostril at bedtime (Flonase is a nasal spray used to treat allergies).
-There was an order for Remeron 15mg at bedtime (Remeron is a medication used to treat insomnia).
-There was an order for Multivitamin one tablet daily (Multivitamin is used to treat vitamin deficiency).
-There was an order for Protonix 40mg daily (Protonix is a proton-pump inhibitor used to treat reflux).
-There was an order for Sennosides-Docusate Sodium 8.6-50mg daily (Sennosides-Docusate Sodium is a medication used to treat constipation).
-There was an order for Seroquel 50mg at bedtime (Seroquel is an anti-psychotic medication used to treat depression and insomnia).
-There was an order for Budesonide 0.5mg/2mL inhale twice daily, scheduled for administration at 8:00am and 8:00pm (Budesonide is a medication used to treat asthma and chronic obstructive pulmonary disease).

Review of Resident #3's facility progress notes dated 04/06/22 at 4:00pm revealed:
-The resident was admitted to the facility from a skilled nursing facility.
-The resident brought medication to the facility.

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D 273	Continued From page 18 Review of Resident #3's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Ascorbic Acid 500mg daily, scheduled for administration at 8:00am. -There was an entry for Aspirin 81mg daily, scheduled for administration at 8:00am. -There was an entry for Atorvastatin 40mg at bedtime, scheduled for administration at 8:00pm. -There was an entry for Calcitriol 0.25mcg daily, scheduled for administration at 8:00am. -There was an entry for Flonase 50mcg in each nostril at bedtime, scheduled for administration at 8:00pm. -There was an entry for Remeron 15mg at bedtime, scheduled for administration at 8:00pm. -There was an entry for Multivitamin one tablet daily, scheduled for administration at 8:00am. -There was an entry for Protonix 40mg daily, scheduled for administration at 8:00am. -There was an entry for Sennosides-Docusate Sodium 8.6-50mg daily, scheduled for administration at 8:00am. -There was an entry for Seroquel 50mg at bedtime, scheduled for administration at 8:00pm. -There was an entry for Budesonide 0.5mg/2mL inhale twice daily, scheduled for administration at 8:00am and 8:00pm. -There was no documentation of any scheduled medication administered on 04/06/22 at 8:00pm or 04/07/22 at 8:00am. Review of a handwritten medication administration record (MAR) for Resident #3 dated 04/07/22 revealed: -Remeron 15mg was documented as administered at 7:30pm. -Atorvastatin 40mg was documented as administered at 7:30pm.	D 273		

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-Seroquel 50mg was documented as administered at 7:30pm.

Review of Resident #3's facility progress notes dated 04/07/22 at 7:55pm revealed the resident was sent to the emergency room for a fall.

Telephone interview with one of the facility's contracted primary care providers on 05/26/22 at 4:00pm revealed:
-She expected residents to have their medications available for administration when they arrived at the facility and that medication administration would be documented.
-She would have expected to be notified of Resident #3 not having her medications available for administration on admission.
-She was concerned that the resident not receiving her Seroquel the evening of 04/06/22 could cause tachycardia and dizziness which put the resident at a risk for falls.

b. Review of Resident #3's current FL-2 dated 04/05/22 revealed diagnoses included stage 4 chronic kidney disease.

Review of Resident #3's facility progress notes dated 05/01/22 at 2:28pm revealed she was sent to the emergency room (ER) for evaluation after a fall and returned to the facility.

Review of Resident #3's facility progress notes dated 05/01/22 at 9:13pm revealed the resident returned to the ER after she passed out and was admitted to the hospital.

Review of Resident #3's hospital discharge summary dated 05/04/22 revealed:
-She was admitted on 05/01/22 with a chief complaint of fall, hip pain, and weakness.

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-Her discharge diagnoses included acute blood loss, hemorrhagic shock, acute renal failure, dementia, urinary tract infection and polypharmacy.
-Her discharge plan was to return to the assisted living facility with follow up appointments for her primary care provider and nephrology.
-She was to follow up at the nephrology clinic in one week to have a repeat urinalysis.

Review of Resident #3's 05/04/22 hospital discharge instructions revealed she had an appointment scheduled at the nephrology clinic on 05/12/22 at 10:30am.

Interview with Resident #3 on 05/26/22 at 11:10am revealed she remembered being at the hospital earlier this month but has not had any doctor visits since then that she could recall.

Interview with the Resident Care Coordinator (RCC) on 05/26/22 at 1:05pm revealed:
-She was responsible for reviewing resident's discharge paperwork upon their return from the hospital.
-She did not receive Resident #3's discharge paperwork when she returned from the hospital on 05/04/22.
-She was in the process of training for the RCC position at the time of Resident #3's discharge on 05/04/22 and was not sure who received Resident #3's paperwork.
-She was concerned that Resident #3 missed her nephrology appointment because of her history of kidney disease and need for a repeat urinalysis.

Interview with the Administrator on 05/26/22 at 2:47pm revealed:
-She was not aware that Resident #3 missed her nephrology appointment that was scheduled for

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05/12/22 upon discharge from the hospital on 05/04/22.
-The RCC was responsible for reviewing discharge paperwork and ensuring that appointments were passed on to the transporter.

Attempted telephone interview with the nephrologist on 05/26/22 at 2:00pm was unsuccessful.

3. Review of Resident #1's current FL-2 dated 05/04/22 revealed:
-Diagnoses included schizoaffective disorder, chronic obstructive pulmonary disease (COPD), blindness in both eyes, and diabetes mellitus type 2 (DM).
-The resident was ambulatory, and her orientation status was not documented.

Review of Resident #1's Resident Register dated 05/04/22 revealed the resident was admitted to the facility on 05/04/22.

Review of Resident #1's care plan dated 05/18/22 revealed:
-The resident was non-ambulatory and required the use of a wheelchair.
-The resident was sometimes disoriented and required reminders.
-The resident required limited assistance with eating and ambulation.
-The resident required total assistance with toileting, bathing, dressing, grooming, and transferring.

a. Review of Resident #1's current FL-2 dated 05/04/22 revealed:
-There was an order for Tylenol 500mg, 2 tablets, every 6 hours as needed for pain for 7 days.
-There was an order for Abilify 10mg daily for 7

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days. (Used to treat schizophrenia and other mood disorders.)
-There was an order for Albuterol 90mcg/actuation, take 2 puffs every 4 hours as needed for wheezing. (Used to treat breathing difficulty in respiratory disorders.)
-There was an order for Glipizide 10mg daily. (An oral medication used to treat DM.)
-There was an order for Spiriva 18mcg/inhalation, take one capsule by inhalation daily. (Used to treat breathing difficulty in respiratory disorders.)
-There was an order for Metformin 500mg, 2 tablets daily with supper for 7 days. (An oral medication to treat DM.)
-There was an order for Symbicort 160-4.5 mcg/actuation, take 2 puffs inhalation twice daily. (Used to treat breathing difficulty in respiratory disorders.)
-There was an order for Seroquel 50mg daily at bedtime for 7 days. (Used to treat mood disorders.)
-There was an order for Lidocaine 4% patches once daily. (Used to treat pain.)
-There was an order for Nicoderm 14mg/24hr patches once daily for 7 days. (Used to treat nicotine withdrawal.)

Review of Resident #1's May 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Tylenol 500mg, 2 tablets, every 6 hours as needed for pain for 7 days.
-The Tylenol was documented as administered on 05/10/22, 05/14/22, 05/15/22, 05/19/22, and 05/24/22.
-The Tylenol was administered beyond 05/11/22 when the order was supposed to be discontinued.
-There was an entry for Abilify 10mg daily for 7 days at 8:00am.
-The Abilify was documented as administered

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daily from 05/07/22-05/13/22, but there was no documentation the Abilify was administered from 05/05/22-05/06/22; the resident missed 2 doses.
-There was an entry for Albuterol 90mcg/actuation, take 2 puffs every 4 hours as needed for wheezing.
-The Albuterol was not documented as administered.
-There was an entry for Glipizide 10mg daily at 8:00am.
-The Glipizide was documented at administered daily from 05/07/22-05/13/22, but there was no documentation the Glipizide was administered from 05/05/22-05/06/22; the resident missed 2 doses.
-There was an entry for Spiriva 18mcg/inhalation, take one capsule by inhalation daily at 8:00am.
-The Spiriva was documented as administered daily from 05/07/22-05/25/22, but there was no documentation the Spriva administered from 05/05/22-05/06/22; the resident missed 2 doses.
-There was an entry for Metformin 500mg, 2 tablets daily with supper for 7 days at 5:00pm.
-The Metformin was documented at administered daily from 05/06/22-05/11/22, but there was no documentation the Metformin was administered on 05/05/22; she only received 6 days total of the medication missing 1 dose.
-There was an entry for Symbicort 160-4.5 mcg/actuation, take 2 puffs inhalation twice daily 8:00am and 8:00pm.
-The Symbicort was documented as administered at 8:00am from 05/07/22-05/25/22 and at 8:00pm from 05/06/22-05/24/22, but there was no documentation the Symbicort was administered on 05/05/22 at 8:00am and 8:00pm and on 05/06/22 at 8:00am; she missed 3 doses.
-There was an entry for Seroquel 50mg daily at bedtime for 7 days at 8:00pm.
-The Seroquel was documented as administered

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from 05/06/22-05/11/22, but there was no documentation the Seroquel was administered on 05/05/22; she missed 1 dose.
-There was an entry for Lidocaine 4% patches once daily.
-The Lidocaine 4% patches were documented as administered from 05/07/22-05/10/22, but there was no documentation the Lidocaine 4% was administered from 05/05/22-05/06/22; she missed 2 doses.
-There was an entry for Nicoderm 14mg/24hr patches once daily for 7 days at 12:00am.
-The Nicoderm patches were documented as administered from 05/09/22-05/11/22, but there was no documentation the Nicoderm was administered from 05/05/22-05/08/22, she missed 4 doses.
-The resident missed 1-4 doses of each of her 9 scheduled daily medications ordered upon admission from 05/05/22-05/08/22.

Review of Resident #1's facility progress notes revealed:
-The resident was admitted to the facility on 05/04/22 from the hospital; it was documented that she had medication with her and that her medication orders had been faxed to the pharmacy.
-There was no documentation that the resident's PCP was notified the resident had missed two days of medications as ordered.

Interview with a medication aide (MA) on 05/26/22 at 10:01am revealed:
-She was not sure why Resident #1 did not have her medications administered as ordered upon admission.
-If a resident was admitted to the facility without their medications on hand, it was the MA's or the Resident Care Coordinator's responsibility to fax

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the resident's medications orders immediately or as soon as possible and request for them to be sent STAT which meant within 2-4 hours.
-If the facility it unable to get the medications within 4 hours then it was the MA's or the RCC's responsibility to call the resident's primary care provider (PCP) to notify them and for guidance and further instruction.

Interview with the RCC on 05/26/22 at 1:05pm revealed:
-She was not aware that Resident #1 had gone without her medications for the first couple of days after her admission and she expected the MA's to have made her aware.
-Resident #1's medications should have been available for administration within four hours of her admission.
-She did not recall Resident #1 having any medications available with her upon admission except an inhaler that was found on the second day.
-It was the MAs responsibility to fax or reorder medications immediately and request them STAT from the pharmacy within four hours as necessary.
-If she had been made aware that Resident #1 did not have her medications administered as ordered upon admission, she would have notified Resident #1's PCP.

Interview with the Administrator on 05/26/22 at 2:27pm revealed:
-Resident #1 was admitted to the facility from the hospital and she had asked the hospital to send a 3-day supply of medications with the resident upon admission.
-The discharge planner at the hospital forgot to send Resident #1's medications with the resident when she was admitted.

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D 273	Continued From page 26 -The facility did not fax Resident #1's medications until the next day and the MA, RCC, or she should have called the resident's PCP to notify her they did not have the medications to administer as ordered. -The facility delayed the resident's care and should have had the resident's medications available to her upon admission as ordered. Interview with Resident #1's PCP on 05/26/22 at 4:00pm revealed: -She expected to be notified if a resident's medications were unavailable for administration as ordered. -Residents should never miss more than one dose of a medication because missing medications could cause a resident harm. -It was especially important to have know that Resident #1 missed doses of Abilify and Seroquel because she would have provided orders for closer monitoring due to the side effect of missing the dose. -Missing doses of Seroquel and Abilify could have led to tachycardia (increased heart rate), sweating, confusion, altered mental status, and dizziness increasing her risk of falls and possibly explaining her behaviors. -Missing doses of insulin could have led to increased blood sugars, altered mental status, confusion, and a trip to the emergency room (ER). -If she had been made aware, she would have gotten involved and assisted the facility in obtaining the medications in a timely manner by contacting the pharmacy and requesting a STAT order. Based on observations, interviews, and record reviews, it was determined that Resident #1 was not interviewable.	D 273		

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D 273	Continued From page 27 Attempted interview with Resident #1's responsible party on 05/26/22 at 9:48am and 3:54pm were unsuccessful. b. Review of Resident #1's History and Physical (H&P) dated 05/09/22 revealed: -The resident was legally blind and had glaucoma. -There was an order to schedule an appointment with an ophthalmologist (specialty eye doctor). Review of Resident #1's record revealed there was no documentation she had seen the ophthalmologist or that an appointment had been made to do so. Interview with the Resident Care Coordinator (RCC) on 05/26/22 at 1:05pm revealed: -Resident #1's ophthalmology appointment had been made that day after it had been brought to her attention. -She was responsible to read provider notes to ensure all orders were implemented accurate and in a timely manner within one business day. -She had read the resident's H&P but missed the order to schedule the appointment. Interview with the Administrator on 05/26/22 at 2:27pm revealed: -The RCC was responsible to ensure Resident #1's PCP visit notes had been reviewed and orders were such as her ophthalmology appointment were made within one business day of receiving the order. -She was not aware the appointment had been missed. -When residents miss important appointments, it could lead to a delay in care and long-term adverse health effects.	D 273		

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-Resident #1's PCP should have been notified that Resident #1's appointment had been missed and was not made yet.

Interview with Resident #1's PCP on 05/26/22 at 4:00pm revealed:
-She expected the facility to implement and carry out orders as written and to be notified when an order was missed.
-She expected the facility to have made Resident #1's ophthalmology appointment as soon as possible after receiving the order so it could be completed within 3 months and she could follow up on the results.

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

Attempted interview with Resident #1's responsible party on 05/26/22 at 9:48am and 3:54pm were unsuccessful.

4. Review of Resident #2's current FL-2 dated 04/27/22 revealed:
-Diagnoses included unstageable left heel wound, schizophrenia, bipolar disorder, depressive disorder, and diabetes mellitus Type 2.
-The resident was intermittently disoriented.
-There was an order to check fasting blood sugar daily and notify primary care provider (PCP) if blood sugar was less than 70 or greater than 250.
-There was an order to check fingerstick blood sugars (FSBS) as needed, notify provider if FSBS is under 70 or over 250.
-There was an order for Lantus, a medication used to stabilize blood glucose levels, inject 34 units daily at 7:30am before breakfast hold if FSBS less than 150 and Lantus 32 units at 5:00pm before supper hold if FSBS less than

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D 273	Continued From page 29 150. Review of Resident #2's PCP's triage note dated 03/20/22 revealed an order to check FSBS each morning before breakfast and with second Lantus administration, notify PCP if FSBS is under 70 or over 250. Review of Resident #2's March 2022 electronic medication administration record (eMAR) revealed: -There was an entry to check fasting blood sugar daily notify PCP if blood sugar is less than 70 or greater than 250. -The fasting blood sugar check was scheduled at 7:30am. -Resident #2's FSBS at 7:30am was documented as 255 on 03/01/22, 556 on 03/03/22, 376 on 03/04/22, 383 on 03/05/22, 323 on 03/06/22, 315 on 03/08/22, 268 on 03/13/22, 423 on 03/11/22, and 327 on 03/30/22. -There was no documentation on the eMAR that the PCP had been notified of Resident #2's elevated blood sugars. -There was an entry to check FSBS before breakfast and at 5:00pm with second Lantus administration. -The FSBS were scheduled for 7:30am and 5:00pm. -Resident #2's FSBS at 5:00pm was documented as 487 on 03/20/22, 290 on 03/21/22, 337 on 03/22/22, 326 on 03/23/22, 348 on 03/24/22, 252 on 03/25/22, 424 on 03/26/22, 294 on 03/27/22, and 312 on 03/30/22. -There was no documentation on the eMAR that the PCP had been notified of Resident #2's elevated blood sugars. Review of Resident #2's progress notes from 03/01/22-03/31/22 revealed:	D 273		

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-There was no documentation that Resident #2's PCP had been notified of her elevated 7:30am FSBS on 03/01/22, 03/03/22, 03/05/22, 03/06/22, 03/08/22, and 03/30/22.
-There was no documentation that Resident #2's PCP had been notified of her elevated 5:00pm FSBS on 03/21/22, 03/23/22, 03/24/22, 03/25/22, 03/27/22, and 03/30/22.

Review of Resident #2's April 2022 eMAR revealed:
-There was an entry to check fasting blood sugar daily notify PCP if blood sugar is less than 70 or greater than 250.
-There was an entry to check FSBS before breakfast and at 5:00pm with second Lantus administration.
-The FSBS were scheduled at 7:30am and 5:00pm.
-Resident #2's 7:30am FSBS was documented as 281 on 04/14/22.
-Resident #2's 5:00pm FSBS was documented as 279 on 04/01/22, 362 on 04/12/22, 350 on 04/13/22, 547 on 04/14/22, 396 on 04/15/22 and 312 on 04/17/22.
-There was no documentation on the eMAR that Resident #2's PCP had been notified of her elevated blood sugars.

Review of Resident #2's progress notes from 04/01/22-04/30/22 revealed:
-There was no documentation that Resident #2's PCP had been notified of her elevated 7:30am FSBS on 04/14/22.
-There was no documentation that Resident #2's PCP had been notified of her elevated 5:00pm FSBS on 04/01/22, 04/12/22, 04/13/22, 04/15/22, and 04/17/22.

Review of Resident #2's record from

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03/01/22-04/30/22 revealed Resident #2 had 25 FSBS that were over 250 and 18 of those FSBS were not reported to her PCP.

Interview with a medication aide (MA) on 05/26/22 at 10:40am revealed if a resident had orders to contact a primary care provider (PCP) if their blood sugar was too high or too low the documentation of the contact would be in the resident's progress notes.

Interview with a second MA on 05/26/22 at 3:30pm revealed:
-All communication with a PCP was entered into a resident's progress note.
-It was important to notify a PCP if a resident's blood sugar was too high or too low because the PCP may give orders to adjust the medications the resident was receiving.

Interview with the Resident Care Coordinator (RCC) on 05/26/22 at 1:12pm revealed:
-If a MA notified a PCP of a resident's blood sugar being out of range it should be documented in that resident's progress note.
-If PCP notification was not documented in the progress note then it was assumed that the PCP had not been notified.
-If Resident #2's blood sugar was over 250 the MA should notify the PCP either by phone call or by texting through a doctor's application that the MA had access to.
-It was important to contact Resident #2's PCP if her blood sugar was elevated because the PCP may want to give the resident an extra dose of insulin to decrease her blood sugar.

Interview with the Administrator on 05/26/22 at 2:47pm revealed:
-MAs were expected to follow PCP orders about

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notification of blood sugars.
-It was concerning that MAs were not notifying Resident #2's PCP of her elevated blood sugars because the PCP may have ordered a short-acting insulin or increased the resident's Lantus dosage based on her blood sugar. (Short-acting insulin works faster to bring down blood sugars. Lantus is a long-acting insulin.)

Telephone interview with Resident #2's PCP on 05/26/22 at 4:03pm revealed:
-It was important that she be notified of all of Resident #2's blood sugars that were out of range so that she would notice trends and could address them the next time she was at the facility.
-If she had been notified that Resident #2's blood sugars were elevated she might have adjusted her insulin dosage or given a one-time order for medication to get her blood sugar back in range.
-Not reporting the elevated blood sugars to her put Resident #2 at risk for experiencing diabetic ketoacidosis or nonketotic hyperglycemia. (Diabetic ketoacidosis is a buildup of acids in the blood. It can happen when blood sugar is too high for too long. Diabetic ketoacidosis can cause coma or death. Nonketotic hyperglycemia occurs when the blood sugar of a person with diabetes becomes too high for a long time. It causes glycine to build up in tissue and organs, particularly the brain.)
-Nonketotic hyperglycemia could cause Resident #2 to have confusion or an altered mental status and could also lead to coma or kidney damage.

_____

The failure of the facility to provide referral and follow up in notifying the resident's primary care provider (PCP) that medications were unavailable for administration as ordered was directly related to the hospitalization of Resident #5 with a

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D 273	Continued From page 33 diagnosis of diabetic ketoacidosis and acute kidney injury requiring a 12 day stay in the intensive care unit at the hospital then requiring an increased level of care in a skilled nursing facility upon hospital discharge. The facility also failed to notify the PCP that resident's #1 and #3 did not have medications upon admission that resulted in a fall and hospital visit for Resident #3 and potential adverse outcomes for Resident #1. The facilty also failed to notify the PCP of Resident #2's FSBS that were outside of ordered parameters and were directly related to the resident's needs for medication evaluation and adjustment putting the resident at risk of diabetic ketoacidosis, kidney, damage, or coma. The facility's failure resulted in serious physical harm, injury, and neglect and constitutes a Type A1 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 05/25/22 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED June 25, 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.	D 358		

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D 358	Continued From page 34 This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 5 of 5 sampled residents (#1, #2, #3, #4, #5) in which medications were unavailable for administration upon admission to the facility (#1, #3, #5), insulin and a pain reliever not administered accurately as ordered (#2), and inaccurate administration of a cholesterol (#4) and pain relieving (#1) medications. The findings are: Review of the facility's Accommodations and Services Assisted Living Resident Agreement dated 05/23/16 revealed: -Residents were to receive services described in their Resident Service Plan to include medication assistance. -Residents were to receive third party services such as pharmacy medication delivery and medication management services from the facility. -The facility was responsible to order all medications and have the necessary supply of medication available. -Residents had the right to receive care and services which were adequate, appropriate, and in compliance with Federal and State laws, rules, and regulations. 1.Review of Resident #5's current FL-2 dated 12/30/19 revealed: -Diagnoses included type 2 diabetes mellitus (DM), acute encephalopathy, anoxic brain injury, and a history of acute respiratory failure.	D 358		

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-The resident was ambulatory and intermittently disoriented.
-There was an order for Lantus 32 units (long acting insulin used to stabilize blood glucose levels) at bedtime.
-There was an order for Humalog 100u/ml 5 units (short acting insulin used lower blood glucose levels) every morning with breakfast.
-There was an order for Humalog 100u/ml 2 units daily with lunch.
-There was an order for Humalog 100u/ml 5 units daily with supper.
-There was an order for Metformin 500mg (an oral medication used to lower blood glucose levels) twice daily with meals.
-There was an order for Lipitor 40mg each night at bedtime. (Used to treat high cholesterol.)
-There was an order for Protonix 40mg daily. (Used to reduce acid produced i the stomach.)
-There was an order for Santyl, 1 application daily. (An ointment used to treat wounds.)
-There was an order for Aspirin 81mg daily. (Used as a blood thinner.)
-There was an order for Senna, 1 tablet daily. (Used to treat constipation.)
-There was an order for Therma, 1 tablet daily. (Used as a multi-vitamin supplement.)
-There was no order to obtain FSBS.

Review of Resident #5's Resident Register dated 01/02/20 revealed the resident was admitted to the facility from the hospital on 01/02/20.

Review of Resident #1's January 2020 electronic medication administration record (eMAR) revealed:
-There was an entry for Lantus 32 units at bedtime at 9:00pm.
-The Lantus 32 units was documented as administered on 01/04/20, but not on

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D 358	Continued From page 36 01/02/20-01/03/20, so the resident missed 2 doses. -There was an entry for Humalog 100u/ml 5 units every morning with breakfast at 8:00am. -The Humalog 5 units with breakfast was documented as administered on 01/04/20-01/05/20, but there was no documentation the Humalog was administered on 01/02/20-01/03/20; the resident missed 2 doses. -There was an entry for Humalog 100u/ml 2 units daily with lunch at 12:00pm. -The Humalog 2 units with lunch was documented as administered on 01/04/20, but there was no documentation that the Humalog was administered on 01/02/20-01/03/20; the resident missed 2 doses. -There was an entry for Humalog 100u/ml 5 units daily with supper at 5:00pm. -The Humalog 5 units with supper was documented as administered on 01/04/20, but there was no documentation that the Humalog was administered on 01/02/20-01/03/20; the resident missed 2 doses. -There was an entry for Metformin 500mg twice daily with meals at 9:00am and 9:00pm. -The Metformin was documented as administered on 01/04/20-01/05/20 at 9:00am, but there was no documentation that the Metformin was administered on 01/02/20-01/03/20; he missed 2 doses. -The Metformin was documented as administered on 01/04/20 at 9:00pm, but there was no documentation that the Metformin was administered on 01/02/20-01/03/20; he missed 2 doses. -There was an entry for Lipitor 40mg each night at bedtime at 9:00pm. -The Lipitor was documented as administered on 01/04/20, but there was no documentation that the Lipitor was administered on	D 358		

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01/02/20-01/03/20; the resident missed 2 doses.
-There was an entry for Protonix 40mg daily at 9:00am.
-The Protonix was documented as administered on 01/04/20-01/05/20, but there was no documentation that the Protonix was administered on 01/02/20-01/03/20; the resident missed 2 doses.
-There was an entry for Santyl, 1 application daily at 9:00am.
-The Santyl was documented as administered on 01/04/20-01/05/20, but there was no documentation that the Santyl was administered on 01/02/20-01/03/20; the resident missed 2 doses.
-The Santyl was also documented as administered on 01/06/20 by home health when the resident was in the hospital.
-There was an entry for Aspirin 81mg daily at 9:00am.
-The Aspirin was documented as administered on 01/04/20-01/05/20, but there was no documentation of Aspirin being administered on 01/02/20-01/03/20; the resident missed 2 doses.
-There was an entry for Senna, 1 tablet daily 5:00pm.
-The Senna was documented as administered on 01/04/20, but there was no documentation that the Senna was administered on 01/02/20-01/03/20; the resident missed 2 doses.
-There was an entry for Therma, 1 tablet daily at 5:00pm.
-The Therma was documented as administered on 01/04/20, but there was no documentation that the Therma was administered on 01/02/20-01/03/20; the resident missed 2 doses.
-There was no entry to obtain FSBS or documentation of FSBS.

Review of Resident #5's vital signs report dated

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D 358	Continued From page 38 01/02/20 through 01/05/20 revealed: -The resident arrived at the facility for admission on 01/02/20 at 8:47am. -There were no FSBS documented for the resident. Review of Resident #5's progress notes revealed: -On 01/03/20 at 6:30pm, it was documented that the facility's contracted pharmacy was contacted to follow up on when the resident's medications were to be delivered due to the resident needing his insulin and being non-compliant with his dietary restrictions; it was too late to request back-up medications from the pharmacy; the responsible party and primary care provider (PCP) were notified. -On 01/03/20 at 8:46pm, the resident was sent to the Emergency Room (ER) due to a high FSBS reading. -On 01/04/20 at 2:25am, the resident returned from the ER and the resident was to follow-up with his PCP on 01/08/20. -On 01/04/20 at 5:02pm, the resident's FSBS was 555 mg/dl (normal FSBS ranges for a person with DM is 80-130 mg/dl); he was given 5 units of Humalog at that time. -On 01/04/20 at 10:16pm, the resident's FSBS was retaken and was 545 mg/dl. -On 01/05/20 at 10:25am, the resident fell in his bedroom doorway, vital signs were obtained, a FSBS was obtained twice, both FSBS results read HI (too high to calculate on the glucometer machine), notification sent to the PCP and responsible party and the resident was sent to the ER where he was admitted for care. -There was no documentation that the resident's PCP was notified that he did not have medications on available for administration on 01/02/20-01/03/20 or that he did not have an order to receive FSBS.	D 358		

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D 358	Continued From page 39 Review of Resident #5's Incident/Accident (I/A) report dated 01/05/20 revealed: -The resident had a witnessed fall in the middle of his bedroom doorway. -The resident stated his "legs gave away" and he was trying to sit up. -The resident did not have injury or pain but was sent to the ER due to high FSBS where he was admitted and diagnosed with diabetic ketoacidosis (DKA) (a serious diabetes complication that occurs when there is not enough insulin in the body and produces excess blood acids (ketones) that requires emergency care that could lead to diabetic coma or death). Review of Resident #5's hospital history and physical (H&P) dated 01/05/20 revealed: -The resident presented to the ER with a history of poorly controlled DM with elevated FSBS along with polyuria (excessive urination), polydipsia (excessive thirst), and nausea. -His blood gases indication uncompensated metabolic acidosis (a serious electrolyte disorder that could result in impaired kidney function, cardiovascular health, or death requiring hospitalization). -The resident was diagnosed with DKA and acute kidney injury and required intravenous insulin and electrolyte and fluid rehydration. -The resident was directly admitted to the intensive care unit (ICU) for further care after stabilization. Review of Resident #5's hospital progress notes dated 01/11/20 and 01/16/20 revealed: -The resident was improving with care and aggressive insulin medication management. -The resident was unable to care for himself due to a history of brain injury and was awaiting a bed	D 358		

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placement in a nursing home.

Review of Resident #5's hospital discharge summary dated 01/17/20 revealed:
-The resident was improving and required aggressive medication management.
-The resident was discharged in stable condition to a skilled nursing facility (increased level of care from assisted living) to continue therapy for further care.

Telephone interview with Resident #5's family member on 05/25/22 at 4:08pm revealed:
-Resident #5 was admitted to the facility on 01/02/20 and was not oriented and unable to make decisions or care for himself.
-Resident #5 did not have any medications on hand when he was admitted to the facility from the hospital on 01/02/20.
-Due to Resident #5 not having his medications for two days, his blood sugars rose to dangerous levels and he was admitted to the hospital in the intensive care unit (ICU).
-She was not made aware on the day of Resident #5's admission that he did not have his medications on hand and the facility staff did not ask her to assist in obtaining the medications.
-She received a call later than night after she left the facility on 01/02/20, that the Resident #5's blood sugar was high, and the facility was sending him to the hospital.
-Resident #5's diagnosis of diabetes mellitus and his need for insulin was not new for him and should have been addressed immediately upon his admission.
-A few days later, Resident #5 fell in his doorway and was sent back to the hospital because his FSBS was high again and that was when he was admitted to the intensive care unit (ICU).
-The facility "neglected" to provide Resident #5

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his insulin and other medications as ordered and that was why he became so sick and eventually needed a higher level of care.

Telephone interview with an order entry technician at the facility's contracted pharmacy on 05/25/22 at 1:50pm revealed:
-The pharmacy received Resident #5's admission medication orders via fax from the facility on 01/03/20 at 12:29pm; the pharmacy had not received any medication orders from the facility prior to that date.
-The pharmacy immediately entered Resident #5's orders into his profile in the computer system and filled the medications to be sent to the pharmacy.
-Resident #5's medications were sent to the facility on 01/03/20 were received at the facility on 01/04/20 at 1:56am.
-The facility did not request the medications to be filled STAT (immediately or urgently), but if the facility had requested the order to be filled STAT, the pharmacy would have had the medications to the facility within four hours or less.

Interview with a medication aide (MA) on 05/25/22 at 2:25pm revealed:
-She had worked at the facility during the time Resident #5 was admitted to the facility on 01/02/20 but did not recall being involved in Resident #5's admission.
-It was the facility's policy for medication aides to fax resident medication orders to the pharmacy immediately upon the resident's arrival for admission.
-Once the orders were faxed to the pharmacy, the pharmacy would enter the orders into the resident's profile in the eMAR computer system and fill the medications to be sent to the facility which usually happened in about 4-24 hours

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depending on whether the facility requested the medications STAT.
-It was the MA's or the Resident Care Coordinator's (RCC'S) responsibility to compare the medications to the orders on the eMAR to the orders received from the provider for accuracy upon receipt of the medications from the pharmacy.
-Residents were not to go longer than four hours without having medications administered to them as ordered and the facility should have requested Resident #5's medications from the pharmacy STAT.
-She was not sure why the facility process was breached, and Resident #5 did not receive his medications as ordered for the first two days of admission.

Interview with the RCC on 05/25/22 at 2:55pm revealed:
-She did not work at the facility when Resident #5 was admitted to the facility on 01/02/20.
-The Administrator was responsible to ensure the facility had an accurate FL-2 with orders and a history and physical for a resident who was to be admitted prior to admission.
-It was her or the MA's responsibility to immediately fax medication orders to the pharmacy upon a resident's admission to ensure medications were on-hand to be administered as ordered.
-The pharmacy normally delivered requested medication to the facility within 24-hours, but the facility was responsible to request STAT processing (within 4 hours) for new admissions to ensure medications were on hand in a timely manner.
-It was unacceptable for a diabetic resident to go longer than one dose without medication because their medications were ordered to treat their

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health needs and the resident's FSBS could go too high.
-She was not sure why the facility delayed faxing Resident #5's medication orders after admission and did not call the pharmacy or the PCP to expedite getting Resident #5's medications on-hand for administration as ordered in a timely manner.

Interview with the Administrator on 05/25/22 at 3:33pm revealed:
-She did not work at the facility when Resident #5 was admitted to the facility on 01/02/22, but the process for admission and administration of medications had not changed.
-The facility was responsible to ensure they were able to meet the resident's needs to include vital medication administration as ordered prior to Resident #5's admission.
-The RCC or the MA's were responsible to immediately fax a resident's medication orders upon a resident's arrival to the facility.
-Medications were typically sent to the facility on the same day or the next day after being faxed to the pharmacy but could have been requested STAT to have them available at the facility sooner.
-Residents should never miss a dose of medication as ordered and the facility should have called Resident #5's hospital provider, PCP, and pharmacy to notify them he was without medications upon admission to remedy the issue and obtain orders to guide his care.
-When residents go without medications it could lead to a bad outcome.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/25/22 at 2:01pm revealed:
-It was the facility's responsibility to fax a

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resident's medication orders to the pharmacy immediately or as soon as possible upon receipt or the resident's arrival to the facility as a new admission.
-The pharmacy would enter new medication orders into the resident's profile in the computer system and fill the medications to be delivered to the pharmacy within the same business day or the next business day of receiving the orders.
-It was the facility's responsibility to notify the pharmacy if medication orders need to be filled STAT, meaning they need it as soon as possible or within four hours of faxing the orders.
-If the facility had faxed Resident #5's orders on the day of his admission and notified the pharmacy they needed his medications STAT, the pharmacy would have ensured the facility received Resident #5's medications within four hours and would have worked with a back-up pharmacy to ensure the medications were received within four hours if the pharmacy was unable to provide the medications as expected.
-If a diabetic resident was to go without insulin longer than four hours of it being needed, it could cause the resident to have increased blood sugars which could lead to a multitude of issues to include diabetic ketoacidosis.
-The pharmacy was very careful to document every correspondence with facility's ensure appropriate follow-up and there was no record that the facility faxed Resident #5's medication orders upon his admission on 01/02/20 or that they called to ensure the orders were filled STAT.
-The facility should have faxed Resident #5's medication orders immediately upon admission and requested the medications be filled STAT.
-The pharmacy was available to the facility 24 hours per day 7 days per week and the pharmacy did not know how to best assist if the facility did not communicate appropriately for resident

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D 358	Continued From page 45 needs. Interview with the facility's contracted primary care provider on 05/25/22 at 11:05am revealed: -She expected the facility to have accurate and complete orders for all residents. -She expected medications to be administered accurately as ordered. -It was the facility's responsibility and priority to ensure a resident's medications were available on hand upon admission or as soon as possible there after not exceeding four hours post admission. -It was inappropriate for the facility to not administer Resident #5's insulin and other medications for 48 hours post-admission and they should have called for an order to monitor the resident's FSBS closely. -The facility might have been able prevent the resident's need to be admitted to the hospital in the ICU for diabetic ketoacidosis if they had accurate orders and administered his insulin as ordered. -It did not take long for a resident with diabetes to have blood sugars that were uncontrollable when they go without their insulin for more than one dose. -Resident #5 missing his insulin for 48 hours caused him to go into diabetic ketoacidosis and the responsible provider at that time should have been notified to intervene and guide his care for his safety. 2. Review of Resident #3's current FL-2 dated 04/05/22 revealed diagnoses included chronic obstructive pulmonary disease, vitamin D deficiency, cognitive communication deficit, insomnia, atherosclerotic heart disease, hyperlipidemia, anxiety, hypertension, coronary atherosclerosis, and stage 4 chronic kidney	D 358		

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disease.

a. Review of Resident #3's current FL-2 dated 04/05/22 revealed:
-There was an order for Ascorbic Acid 500mg daily (Ascorbic Acid is a medication used for Vitamin C replacement).
-There was an order for Aspirin 81mg daily (Aspirin is a medication used to treat pain and inflammation).
-There was an order for Atorvastatin 40mg at bedtime (Atorvastatin is a medication used to treat high cholesterol).
-There was an order for Calcitriol 0.25mcg daily (Calcitriol is a form of vitamin D used to treat patients with chronic kidney disease).
-There was an order for Flonase 50mcg in each nostril at bedtime (Flonase is a nasal spray used to treat allergies).
-There was an order for Remeron 15mg at bedtime (Remeron is a medication used to treat insomnia).
-There was an order for Multivitamin one tablet daily (Multivitamin is used to treat vitamin deficiency).
-There was an order for Protonix 40mg daily (Protonix is used to reduce acid produced by the stomach).
-There was an order for Sennosides-Docusate Sodium 8.6-50mg daily (Sennosides-Docusate Sodium is a medication used to treat constipation).
-There was an order for Seroquel 50mg at bedtime (Seroquel is an anti-psychotic medication used to treat depression and insomnia).

Review of Resident #3's facility progress notes dated 04/06/22 at 4:00pm revealed:
-The resident was admitted to the facility from a skilled nursing facility.

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D 358	Continued From page 47 -The resident brought medication to the facility. Review of Resident #3's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Ascorbic Acid 500mg daily, scheduled for administration at 8:00am. -There was an entry for Aspirin 81mg daily, scheduled for administration at 8:00am. -There was an entry for Atorvastatin 40mg at bedtime, scheduled for administration at 8:00pm. -There was an entry for Calcitriol 0.25mcg daily, scheduled for administration at 8:00am. -There was an entry for Flonase 50mcg in each nostril at bedtime, scheduled for administration at 8:00pm. -There was an entry for Remeron 15mg at bedtime, scheduled for administration at 8:00pm. -There was an entry for Multivitamin one tablet daily, scheduled for administration at 8:00am. -There was an entry for Protonix 40mg daily, scheduled for administration at 8:00am. -There was an entry for Sennosides-Docusate Sodium 8.6-50mg daily, scheduled for administration at 8:00am. -There was an entry for Seroquel 50mg at bedtime, scheduled for administration at 8:00pm. -There was an entry for Budesonide suspension 0.5mg/2mL inhale twice daily, scheduled for administration at 8:00am and 8:00pm. -There was no documentation of any scheduled medication administered on 04/06/22 at 8:00pm or 04/07/22 at 8:00am. Review of a handwritten medication administration record (MAR) for Resident #3 dated 04/07/22 revealed: -Remeron 15mg was documented as administered at 7:30pm. -Atorvastatin 40mg was documented as	D 358		

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administered at 7:30pm.
-Seroquel 50mg was documented as administered at 7:30pm.

Review of Resident #3's facility progress notes dated 04/07/22 at 7:55pm revealed the resident was sent to the emergency room for a fall.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/26/22 at 11:05am revealed:
-They received a fax of Resident #3's FL-2 on 04/06/22 at 3:41pm.
-The pharmacy contacted the facility after receiving the fax on 04/06/22 to make them aware that they could not enter the resident's profile of medication into the computer system until the resident was physically in the building.
-The medications were entered into the system on 04/07/22 by the pharmacy after the facility had verified the resident's allergies.
-The facility did not request to have any of Resident #3's medications dispensed until 04/11/22.

Interview with the Administrator on 05/26/22 at 2:47pm revealed:
-She was not aware if Resident #3 received her evening medication on 04/06/22 or her daily medications on 04/07/22 because there was no documentation.
-Staff were expected to document on handwritten MARs if the resident received medications and it was not entered into the computer profile by the pharmacy.

Telephone interview with one of the facility's contracted primary care providers on 05/26/22 at 4:00pm revealed:
-She expected residents to have their

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medications available for administration when they arrived at the facility and that medication administration would be documented.
-She was concerned that the resident not receiving her Seroquel the evening of 04/06/22 could cause tachycardia and dizziness which put the resident at a risk for falls.

b. Review of Resident #3's current FL-2 dated 04/05/22 revealed:
-There was an order for Seroquel 50mg at bedtime (Seroquel is an antipsychotic medication).
-There was an order for Remeron 15mg at bedtime (Remeron is an antidepressant used to treat anxiety and/or insomnia).

Review of Resident #3's hospital discharge summary dated 05/04/22 revealed:
-She was admitted on 05/01/22 with a chief complaint of fall, hip pain, and weakness.
-Her discharge diagnoses included acute blood loss, hemorrhagic shock, acute renal failure, dementia, urinary tract infection and polypharmacy.
-The likely reason for her fall was due to polypharmacy; prior to admission to the hospital she was on Seroquel, Melatonin, and Remeron at bedtime.
-Discharge medications included reducing Seroquel to 12.5mg at bedtime.
-Discharge medications included reducing Remeron from 15mg to 7.5mg at bedtime.

Review of Resident #3's May 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Seroquel 50mg to be given at bedtime, scheduled for administration at 8:00pm.

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-Seroquel 50 mg was documented administered 05/04/22, 05/06/22 and 05/13/22 through 05/24/22 at 8:00pm.
-Seroquel 50mg was documented as 'on hold' on 05/05/022, 05/07/22, 05/08/22, 05/11/22 and 05/12/22.
-Seroquel 50mg was documented as discontinued on 05/09/22 and 05/10/22.
-There was an entry for Remeron 15mg to be given at bedtime, scheduled for administration at 8:00pm.
-Remeron 15mg was documented as administered 05/04/22 to 05/08/22 and from 05/13/22 to 05/24/22 at 8:00pm.
-Remeron 15mg was documented as held 05/09/22 to 05/12/22 awaiting pharmacy refill.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 05/26/22 at 10:48am revealed the pharmacy did not receive a fax of Resident #3's discharge medication from her 05/04/22 hospitalization.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/26/22 at 11:05am revealed:
-If a resident had a history of falls and was treated at the hospital for polypharmacy it was important for staff to fax the discharge paperwork so that the pharmacy could enter the changes in orders correctly.
-A resident that continued to receive a higher dose of Seroquel or Remeron than order was at an increased risk for falls and lethargy.

Interview with the Resident Care Coordinator (RCC) on 05/26/22 at 1:05pm revealed:
-She was responsible for reviewing resident's discharge paperwork upon their return from the hospital.

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D 358	Continued From page 51 -She did not receive Resident #3's discharge paperwork when she returned from the hospital on 05/04/22. -She was in the process of training for the RCC position at the time of Resident #3's discharge on 05/04/22 and was not sure who received Resident #3's paperwork. -She was responsible for faxing Resident #3's discharge paperwork to the pharmacy so that they could update her doses of Seroquel and Remeron. -She did not read Resident #3's discharge paperwork when she was discharged from the hospital on 05/04/22. Interview with the Administrator on 05/26/22 at 2:47pm revealed: -She was not aware that Resident #3 had medication changes that were not completed upon discharge from the hospital on 05/04/22. -The RCC was responsible for reviewing discharge paperwork and ensuring that discharge medications were faxed to the pharmacy. -She expected Resident #3 to receive her medication as ordered, including her Remeron and Seroquel. 3. Review of Resident #1's current FL-2 dated 05/04/22 revealed: -Diagnoses included schizoaffective disorder, chronic obstructive pulmonary disease (COPD), blindness in both eyes, and diabetes mellitus type 2 (DM). -The resident was ambulatory, and her orientation status was not documented. -There was an order for Tylenol 500mg, 2 tablets, every 6 hours as needed for pain for 7 days. -There was an order for Abilify 10mg daily for 7 days. (Used to treat schizophrenia and other mood disorders.)	D 358		

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-There was an order for Albuterol 90mcg/actuation, take 2 puffs every 4 hours as needed for wheezing. (Used to treat breathing difficulty in respiratory disorders.)
-There was an order for Glipizide 10mg daily. (An oral medication used to treat DM.)
-There was an order for Spiriva 18mcg/inhalation, take one capsule by inhalation daily. (Used to treat breathing difficulty in respiratory disorders.)
-There was an order for Metformin 500mg, 2 tablets daily with supper for 7 days. (An oral medication to treat DM.)
-There was an order for Symbicort 160-4.5 mcg/actuation, take 2 puffs inhalation twice daily. (Used to treat breathing difficulty in respiratory disorders.)
-There was an order for Seroquel 50mg daily at bedtime for 7 days. (Used to treat mood disorders.)
-There was an order for Lidocaine 4% patches once daily. (Used to treat pain.)
-There was an order for Nicoderm 14mg/24hr patches once daily for 7 days. (Used to treat nicotine withdrawal.)

Review of Resident #1's Resident Register dated 05/04/22 revealed the resident was admitted to the facility on 05/04/22.

Review of Resident #1's facility progress notes revealed:
-The resident was admitted to the facility on 05/04/22 from the hospital; it was documented that she had medication with her and that her medication orders had been faxed to the pharmacy.
-There was no documentation of what medications the resident brought with her.
-On 05/05/22 at 4:35am, it was documented that the resident had behaviors and the Resident Care

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D 358	Continued From page 53 Coordinator (RCC) was notified. -On 05/05/22 at 10:39am, the resident's primary care provider (PCP) was notified that the resident had been cursing and yelling down the hallway while being aggressive toward staff. -On 05/05/22 at 11:08pm, the resident was documented to have behaviors that were reported to the RCC. -On 05/06/22 at 10:08pm, the resident was documented to have behaviors that were reported to the RCC. -On 05/07/22 at 5:25am, the resident was documented to have behaviors that were reported to the RCC. -On 05/08/22 at 8:57pm, the resident was documented to have behaviors that were reported to the RCC. -On 05/08/22 at 9:10pm, the resident was documented as being combative, cursing, knocking other resident's items over, and pulling the call bell out of the wall socket; the resident's PCP was notified. Review of Resident #1's May 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Tylenol 500mg, 2 tablets, every 6 hours as needed for pain for 7 days. -The Tylenol was documented as administered on 05/10/22, 05/14/22, 05/15/22, 05/19/22, and 05/24/22. -The Tylenol was administered beyond 05/11/22 when the order was supposed to be discontinued. -There was an entry for Abilify 10mg daily for 7 days at 8:00am. -The Abilify was documented as administered daily from 05/07/22-05/13/22, but there was no documentation the Abilify was administered from 05/05/22-05/06/22; the resident missed 2 doses. -There was an entry for Albuterol	D 358		

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90mcg/actuation, take 2 puffs every 4 hours as needed for wheezing.
-The Albuterol was not documented as administered.
-There was an entry for Glipizide 10mg daily at 8:00am.
-The Glipizide was documented at administered daily from 05/07/22-05/13/22, but there was no documentation the Glipizide was administered from 05/05/22-05/06/22; the resident missed 2 doses.
-There was an entry for Spiriva 18mcg/inhalation, take one capsule by inhalation daily at 8:00am.
-The Spiriva was documented as administered daily from 05/07/22-05/25/22, but there was no documentation the Spriva was administered from 05/05/22-05/06/22; the resident missed 2 doses.
-There was an entry for Metformin 500mg, 2 tablets daily with supper for 7 days at 5:00pm.
-The Metformin was documented at administered daily from 05/06/22-05/11/22, but there was no documentation the Metformin was administered on 05/05/22; the resident only received 6 days total of the medication missing 1 dose.
-There was an entry for Symbicort 160-4.5 mcg/actuation, take 2 puffs inhalation twice daily 8:00am and 8:00pm.
-The Symbicort was documented at 8:00am from 05/07/22-05/25/22 and at 8:00pm from 05/06/22-05/24/22, but there was no documentation the Symbicort was administered from 05/05/22 at 8:00am and 8:00pm and on 05/06/22 at 8:00am; the resident missed 3 doses.
-There was an entry for Seroquel 50mg daily at bedtime for 7 days at 8:00pm.
-The Seroquel was documented as administered from 05/06/22-05/11/22, but there was no documentation the Seroquel was administered on 05/05/22; the resident missed 1 dose.
-There was an entry for Lidocaine 4% patches

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once daily.
-The Lidocaine 4% patches were documented as administered from 05/07/22-05/10-22, but there was no documentation the Lidocaine 4% was administered from 05/05/22-05/06/22; the resident missed 2 doses.
-There was an entry for Nicoderm 14mg/24hr patches once daily for 7 days at 12:00am.
-The Nicoderm patches were documented as administered from 05/09/22-05/11/22, but there was no documentation the Nicoderm was administered from 05/05/22-05/08/22; the resident missed 4 doses.
-The resident missed 1-4 doses of each of her 9 scheduled daily medications ordered upon admission from 05/05/22-05/08/22.

Interview with a medication aide (MA) on 05/26/22 at 10:01am revealed:
-She was not sure why Resident #1 did not have her medications administered as ordered upon admission.
-If a resident was admitted to the facility without their medications on hand, it was the MA's or the Resident Care Coordinator's (RCC) responsibility to fax the resident's medications orders immediately or as soon as possible and request for them to be sent STAT which meant within 2-4 hours.
-If the facility it unable to get the medications within 4 hours then it was the MA's or the RCC's responsibility to call the resident's primary care provider to notify them and for guidance and further orders.

Interview with the RCC on 05/26/22 at 1:05pm revealed:
-She was not aware that Resident #1 had gone without her medications for the first couple of days after her admission and she expected the

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MA's to have made her aware.
-Resident #1's medications should have been available for administration within four hours of her admission.
-She did not recall Resident #1 having any medications available with her upon admission except an inhaler that was found on the second day.
-It was the MAs responsibility to fax or reorder medications immediately and request them STAT from the pharmacy within four hours as necessary.

Interview with the Administrator on 05/26/22 at 2:27pm revealed:
-Resident #1 was admitted to the facility from the hospital and she had asked the hospital to send a 3-day supply of medications with the resident upon admission.
-The discharge planner at the hospital forgot to send Resident #1's medications with the resident when she was admitted.
-The facility did not fax Resident #1's medications until the next day and the MA, RCC, or she should have called the resident's PCP to notify her they did not have the medications to administer as ordered.
-The facility delayed the resident's care and should have had the resident's medications available to her upon admission as ordered.

Interview with Resident #1's PCP on 05/26/22 at 4:00pm revealed:
-Residents should never miss more than one dose of a medication because missing medications could cause a resident harm.
-She expected medications to be administered accurately as ordered to prevent adverse reactions and outcomes and it should be an utmost priority for resident safety.

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-She expected the facility to fax and order medications from the pharmacy in a timely manner to prevent missed doses and adverse outcomes.
-It was especially important to have known that Resident #1 missed doses of Abilify and Seroquel because she would have provided orders for closer monitoring due to the side effect of missing the dose.
-Missing doses of Seroquel and Abilify could have led to tachycardia (increased heart rate), sweating, confusion, altered mental status, and dizziness increasing her risk of falls and possibly explaining her behaviors.
-If she had been made aware, she would have gotten involved and assisted the facility in obtaining the medications in a timely manner by contacting the pharmacy and issuing a STAT order to file the medications.

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

Attempted interview with Resident #1's responsible party on 05/26/22 at 9:48am and 3:54pm were unsuccessful.

4. Review of Resident #2's current FL-2 dated 04/27/22 revealed:
-Diagnoses included unstageable left heel wound, schizophrenia, bipolar disorder, depressive disorder, and diabetes mellitus Type 2.
-The resident was intermittently disoriented.

a. Review of Resident #2's current FL-2 dated 04/27/22 revealed there was an order for Lantus inject 34 units daily at 7:30am before breakfast, hold if fingerstick blood sugar (FSBS) less than 150 and 32 units at 5:00pm before supper, hold if

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D 358	Continued From page 58 FSBS less than 150. (Lantus is a long-acting insulin used to control high blood sugar.) Review of Resident #2's May 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Lantus inject 34 units daily at 7:30am before breakfast, hold if FSBS less than 150 and inject 32 units at 5:00pm before supper, hold if FSBS less than 150. -On 05/02/22 at 7:30am Resident #2's FSBS was 113 and 34 units of Lantus was documented as administered. -On 05/05/22 at 7:30am Resident #2's FSBS was 74 and 34 units of Lantus was documented as administered. -On 05/08/22 at 7:30am Resident #2's FSBS was 139 and 34 units of Lantus was documented as administered. -On 05/11/22 at 7:30am Resident #2's FSBS was 121 and 34 units of Lantus was documented as administered. -On 05/16/22 at 7:30am Resident #2's FSBS was 100 and 42 units of Lantus was documented as administered. -On 05/17/22 at 7:30am Resident #2's FSBS was 90 and 34 units of Lantus was documented as administered. -On 05/18/22 at 7:30am Resident #2's FSBS was 148 and 34 units of Lantus was documented as administered. Interview with Resident #2 on 05/25/22 at 8:36am revealed as far as she knew she received her medications as she should. Interview with a medication aide (MA) on 05/26/22 at 3:30pm revealed if Resident #2's FSBS was less than 150 she would not administer the resident's Lantus and would	D 358		

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document it on the eMAR that she did not administer it.

Interview with the Resident Care Coordinator (RCC) on 05/26/22 at 1:12 pm revealed:
-MAs were expected to administer medications as ordered by the primary care provider (PCP).
-MAs should administer medications according to what was entered on the eMAR.
-Administering Lantus to Resident #2 when her blood sugar was less than 150 could cause her blood sugar to drop even more.

Interview with the Administrator on 05/26/22 at 2:47pm revealed:
-MAs were expected to administer medications accurately and as they were trained to do when they were hired by the facility.
-MAs should follow PCP orders and administer Resident #2's Lantus according to the parameters ordered by the PCP.
-Resident #2 often refused to eat and if she received her Lantus when her blood sugar was less than 150 it could cause her blood sugar to go too low.

Telephone interview with Resident #2's PCP on 05/26/22 at 4:03pm revealed:
-She ordered to hold Resident #2's Lantus if her blood sugar was less than 150 because the resident often became depressed and would not eat.
-It was concerning that MAs were giving Resident #2 Lantus when her blood sugar was less than 150 because it could cause her blood sugar to go even lower.
-If Resident #2's blood sugar was too low it was dangerous to give her Lantus because it could cause her to become hypoglycemic. (Hypoglycemia is a low blood sugar.)

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D 358	Continued From page 60 -Hypoglycemia caused the brain not to get enough glucose which could lead to coma or death. b. Review of Resident #2's current FL-2 dated 04/27/22 revealed there was an order for Lantus inject 34 units daily at 7:30am before breakfast, hold if fingerstick blood sugar (FSBS) less than 150 and 32 units at 5:00pm before supper, hold if FSBS less than 150. Review of Resident #2's May 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Lantus inject 34 units daily at 7:30am before breakfast, hold if FSBS less than 150 and inject 32 units at 5:00pm before supper, hold if FSBS less than 150. -At 7:30am on 05/20/22, 05/22/22, and 05/25/22 it was documented that 32 units of Lantus was administered to Resident #2 instead of 34 units. -At 7:30am on 05/16/22 it was documented that 42 units of Lantus was administered to Resident #2 instead of 34 units. Interview with Resident #2 on 05/25/22 at 8:36am revealed as far as she knew she received her medications like she should. Interview with the Resident Care Coordinator (RCC) on 05/26/22 at 1:12 pm revealed: -MAs were expected to administer medications as ordered by the primary care provider (PCP). -MAs should administer medications according to what was entered on the eMAR. -Administering the wrong dose of Lantus to Resident #2 could cause her blood sugars to become too low or too high. Interview with the Administrator on 05/26/22 at	D 358		

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2:47 pm revealed:
-MAs were expected to administer medications accurately and as they were trained to do when they were hired by the facility.
-It appeared that when the MA gave Resident #2 32 units of Lantus instead of the 34 units that was ordered at 7:30am on 05/20/22, 05/22/22, and 05/25/22 they accidentally gave the 5:30pm dose instead.

Telephone interview with Resident #2's PCP on 05/26/22 at 4:03pm revealed she expected MAs to administer medications as ordered.

c. Review of Resident #2's physician order sheet dated 04/27/22 revealed:
-There was an order for Sulfamethoxazole-Trimethoprim 800-160mg twice daily for 14 days.
(Sulfamethoxazole-Trimethoprim is an antibiotic used to treat infections.)
-The start date on the order was 04/25/22.

Review of a dispensing record from the facility's contracted pharmacy revealed 28 tablets of Sulfamethoxazole-Trimethoprim were dispensed for Resident #2 on 04/24/22.

Review of Resident #2's April 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Sulfamethoxazole-Trimethoprim 800-160mg to be administered at 8:00am and 8:00pm and there was a start date of 04/25/22 and an end date of 05/07/22 on the eMAR for the Sulfamethoxazole-Trimethoprim.
-The Sulfamethoxazole-Trimethoprim was documented as administered at 8:00am and 8:00pm on 04/26/22-04/30/22.

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-The Sulfamethoxazole-Trimethoprim was documented as not administered at 8:00pm on 04/25/22 because of resident refusal.
-Resident #2 was administered 10 tablets of Sulfamethoxazole-Trimethoprim from 04/26/22-04/30/22.

Review of Resident #2's May 2022 eMAR revealed:
-There was an entry for Sulfamethoxazole-Trimethoprim 800-160mg to be administered at 8:00am and 8:00pm and there was a start date of 04/25/22 and end date of 05/07/22 on the eMAR for the Sulfamethoxazole-Trimethoprim.
-The Sulfamethoxazole-Trimethoprim was documented as administered at 8:00am and 8:00pm on 05/01/22-05/07/22.
-Resident #2 was administered 14 tablets of Sulfamethoxazole-Trimethoprim from 05/01/22-05/07/22.
-Resident #2 did not receive her last 4 doses of Sulfamethoxazole-Trimethoprim.

Observation of Resident #2's medications on hand on 05/26/22 at 10:40am revealed there was no Sulfamethoxazole-Trimethoprim on the medication cart for Resident #2.

Interview with the Resident Care Coordinator (RCC) on 05/26/22 at 1:12 pm revealed:
-Resident #2 should have received all 14 days of her antibiotic as ordered by the primary care provider (PCP).
-It was important that Resident #2 received all her doses because her infection could have gotten worse or reoccurred.
-The facility's contracted pharmacy put the start dates and end dates on the eMARs but she could adjust the days to make sure the resident

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received all 14 days of her Sulfamethoxazole-Trimethoprim.
-A MA should have made her aware that the amount of days was wrong on the eMAR so she could have adjusted it.

Interview with the Administrator on 05/26/22 at 2:47 pm revealed:
-Medication start dates and end dates were entered onto the eMAR by the facility's contracted pharmacy.
-The end date for Resident #2's Sulfamethoxazole-Trimethoprim was entered incorrectly onto the eMAR.
-The RCC could adjust the end date on the eMAR so that Resident #2 received her full dose of Sulfamethoxazole-Trimethoprim.
-When the MA saw that Resident #2 had more tablets of Sulfamethoxazole-Trimethoprim left they should have notified the RCC so she could adjust the dates on the eMAR so the resident would get her full dose of antibiotics.
-Not finishing her full course of antibiotics could have caused Resident #2 to develop sepsis. (Sepsis is the body's response to an infection. Sepsis occurs when someone has an infection and it triggers a reaction in the body.)

Telephone interview with Resident #2's PCP on 05/26/22 at 4:03pm revealed she ordered Resident #2 14 days of antibiotics to make sure her infection was adequately treated.

5. Review of Resident #4's current FL-2 dated 02/14/22 revealed:
-Diagnoses included type 2 diabetes, meningitis, and hypertension (high blood pressure).
-There was an order for Colestipol 2gm daily (Colestipol is used to lower cholesterol).

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Review of Resident #4's May 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Colestipol 2 gm to be given daily, scheduled for administration at 8:00am.
-Colestipol 2gm was documented as not administered on 05/03/22 through 05/07/22 due to waiting on the medication from pharmacy.

Observation of Resident #4's medications on hand 05/26/22 at 9:10am revealed there was a bubble medication packet of Colestipol 1gm tablets with instructions to administer 2 tablets daily.

Interview with a medication aide (MA) on 05/26/22 at 9:11am revealed:
-When a medication was in a bubble packet and not in a multidose packet then you must fax the request to pharmacy for the refill.
-Multidose packets are on automatic refill and arrive at the facility Thursday evenings.
-Medications that require refill faxes should be sent to the pharmacy when there was a week supply left.

Review of the pharmacy dispensing records for Resident #4's Colestipol 2gm revealed the facility requested a refill on 05/06/22.

Interview with the Resident Care Coordinator (RCC) on 05/26/22 at 1:05pm revealed:
-She was not aware that Resident #4 did not receive 4 doses of her Colestipol.
-She expected MAs to fax the pharmacy a refill request when they are down to 7 days left of the medication.
-If the MA was not able to get the medication timely, she should have been notified so that she

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could contact the pharmacy.

Interview with the Administrator on 05/26/22 at 2:47pm revealed she expected Resident #4 to receive her Colestipol as ordered and she was not aware of 4 missed doses.

Telephone interview with Resident #4's primary care provider (PCP) on 05/26/22 at 4:00pm revealed:
-She was not aware that Resident #4 missed 4 consecutive doses of Colestipol.
-She would have expected to be notified after one missed dose of a medication.

6. Review of Resident #1's current FL-2 dated 05/04/22 revealed:
-Diagnoses included schizoaffective disorder, chronic obstructive pulmonary disease (COPD), blindness in both eyes, and diabetes mellitus type 2 (DM).
-There was an order for Tylenol 500mg, 2 tablets, every 6 hours as needed for pain for 7 days.

Review of Resident #1's standing house orders dated 05/10/22 revealed there was an order for Tylenol 500mg, 1 tablet every 6 hours as needed for fever, minor headache, or minor discomfort.

Review of Resident #1's May 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Tylenol 500mg, 2 tablets, every 6 hours as needed for pain for 7 days.
-The Tylenol was documented as administered on 05/10/22, 05/14/22, 05/15/22, 05/19/22, and 05/24/22.
-The Tylenol was administered beyond 05/11/22 when the order was supposed to be discontinued.
-There was no entry to Tylenol 500mg, 1 tablet

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every 6 hours as needed for fever, minor headache, or minor discomfort.

Interview with a pharmacist with the facility's contracted pharmacy on 05/26/22 at 11:12am revealed:
-The facility was responsible to fax all medication orders to the pharmacy to ensure orders were accurately entered on the resident's eMAR for accurate medication administration.
-The facility was responsible to ensure medications were administered and documented accurately as ordered.
-The pharmacy did not have an active order on file for Resident #1 to receive Tylenol 500mg, 1 tablet every 6 hours as needed for fever, minor headache, or minor discomfort.

Interview with the Resident Care Coordinator on 05/26/22 at 1:05pm revealed:
-She expected residents to be administered medications accurately, on time, and to have them documented as such on their eMAR accurately.
-She expected resident's eMARs to be accurate to ensure accurate and safe medication administration to reduce the risk of medication errors.
-She tried to do cart audits every Friday but they were no specific audits that looked at resident's medication orders and comparing them to medications on hand or eMARs so it wouldn't have caught this issue.
-She did not do specific cart audits because she had never been taught to do so otherwise.
-The residents Tylenol 500mg, 2 tablets as needed for pain for 7 days should have been discontinued on the eMAR and the resident's standing order for Tylenol 500mg, 1 tablet as needed should have been on the eMAR

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D 358	Continued From page 67 accurately. Interview with the Administrator on 05/26/22 at 2:27pm revealed: -She expected medications to be administered accurately as ordered and documented on the eMAR accurately as ordered as well. -The facility had a history of missing orders and had implemented a new process on 05/13/22 in which the MAs would make a copy of all orders for the RCC so they could audit orders and prevent missing further orders. -There was a process for staff to conduct cart audits but she was not aware staff were not taught to specifically compare resident's orders to the eMARs to the medications on hand for accuracy. Interview with Resident #1's PCP on 05/26/22 at 4:00pm revealed: -She expected medications to be administered accurately as ordered to prevent adverse reactions and outcomes and it should be an utmost priority for resident safety. -She expected medications to be documented on the eMAR accurately as ordered to reflect accurate orders and ensure safety of medication administration to prevent medication errors for resident safety. Attempted interview with Resident #1 on 05/26/22 at 10:14am and 10:33am revealed she was not interviewable. Attempted interview with Resident #1's responsible party on 05/26/22 at 9:48am and 3:54pm were unsuccessful. The failure of the facility to obtain and ensure medications were available for administration for	D 358		

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D 358	Continued From page 68 two days upon admission as ordered was directly related to the hospitalization of Resident #5 with a diagnosis of diabetic ketoacidosis and acute kidney injury requiring a 12 day stay in the intensive care unit at the hospital then requiring an increased level of care in a skilled nursing facility upon hospital discharge. The facility also failed to ensure Residents #1 and #3 had medications upon admission which resulted in a fall and hospital visit for Resident #3 and potential adverse outcomes for Resident #1. The facilty also failed to administer Resident #2's insulin accurately as ordered with FSBS that were outside of ordered parameters and were directly related to the resident's needs for medication evaluation and adjustment putting the resident at risk of diabetic ketoacidosis, kidney, damage, or coma. The facility's failure resulted in serious physical harm, injury, and neglect and constitutes a Type A1 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 05/25/22 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED June 25, 2022.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication	D 367		

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administered;
(4) instructions for administering the medication or treatment;
(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure medication administration records were complete and accurate for 2 of 5 residents sampled including multiple medications that were documented as administered when they were not in the building (#3) and orders to notify the primary care provider of blood sugars (#2).

The findings are:

1. Review of Resident #3's current FL-2 dated 04/05/22 revealed diagnoses included stage 4 chronic kidney disease, chronic obstructive pulmonary disease, anxiety disorder, vitamin D deficiency, insomnia, unsteady gait and difficulty walking.

Review of Resident #3's discharge summary dated 05/04/22 revealed:
-There was an order for Aspirin 81mg, 1 tablet daily (Aspirin is a medication used to treat pain and inflammation).
-There was an order for Calcitriol 0.25mcg, 1

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tablet daily (Calcitriol is a form of vitamin D used to treat patients with chronic kidney disease).
-There was an order for Multivitamin, 1 tablet daily (Multivitamin is used to treat vitamin deficiency).
-There was an order for Sennosides-Docusate Sodium 8.6-50mg, 1 tablet daily (Sennosides-Docusate Sodium is a medication used to treat constipation).

Review of Resident #3's May 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Aspirin 81mg give 1 tablet daily, scheduled for administration at 8:00am.
-Aspirin 81mg was documented held 05/09/22, 05/10/22, 05/12/22 and 05/13/22 due to medication not being available.
-Aspirin 81mg was documented as administered on 05/11/22 at 8:00am.
-There was an entry for Calcitriol 0.25mcg give 1 tablet daily, scheduled for administration at 8:00am.
-Calcitriol 0.25mcg was documented held 05/09/22, 05/10/22, 05/12/22 and 05/13/22 due to medication not being available.
- Calcitriol 0.25mcg was documented as administered on 05/11/22 at 8:00am.
-There was an entry for Multivitamin give 1 tablet daily, scheduled for administration at 8:00am.
-Multivitamin 1 tablet was documented held 05/09/22, 05/10/22, 05/12/22 and 05/13/22 due to medication not being available.
-Multivitamin 1 tablet was documented as administered on 05/11/22 at 8:00am.
-There was an order for Sennosides-Docusate Sodium 8.6-50mg give 1 tablet daily, scheduled for administration at 8:00am.
-Sennosides-Docusate Sodium 8.6-50mg was documented held 05/09/22, 05/10/22, 05/12/22

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and 05/13/22 due to medication not being available.
-Sennosides-Docusate Sodium 8.6-50mg was documented as administered on 05/11/22 at 8:00am.

Interview with a medication aide (MA) on 05/26/22 at 3:30pm revealed if a medication was not available for administration it was to be documented as not given and the reason was to be entered.

Interview with the Resident Care Coordinator (RCC) on 05/26/22 at 1:10pm revealed she expected the medication aides (MA) to document completely and accurately on the electronic medication administration record (eMAR).

Interview with the Administrator on 05/26/22 at 2:47pm revealed:
-She expected the MA to document completely and accurately on the eMAR.
-Resident #3 returned from the hospital on 05/04/22 with 4 days worth of medication.

Refer to interview with the RCC on 05/26/22 at 1:10pm.

Refer to telephone interview with the facility's contracted primary care provider (PCP) on 05/26/22 at 4:00pm.

2. Review of Resident #2's current FL-2 dated 04/27/22 revealed:
-Diagnoses included unstageable left heel wound, schizophrenia, bipolar disorder, depressive disorder, and diabetes mellitus Type 2.
-There was an order for Lantus, a medication used to stabilize blood glucose levels, inject 34 units daily at 7:30am before breakfast hold if

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fingerstick blood sugar (FSBS) less than 150 and Lantus 32 units at 5:00pm before supper hold if FSBS less than 150.

Review of Resident #2's primary care provider (PCP) triage note dated 03/20/22 revealed an order to check FSBS each morning before breakfast and with second Lantus administration, notify PCP if FSBS is under 70 or over 250.

Review of Resident #2's March 2022 electronic medication administration record (eMAR) revealed:
-There was an entry with a start date of 03/15/22 to check fingerstick blood sugar (FSBS) before breakfast and at 5:00pm with second Lantus administration.
-There was no entry to notify the PCP if FSBS was under 70 or over 250.

Review of Resident #2's April 2022 eMAR revealed:
-There was an entry to check FSBS before breakfast and at 5:00pm with second Lantus administration.
-There was no entry to notify the PCP if FSBS was under 70 or over 250.

Refer to interview with the Resident Care Coordinator (RCC) on 05/26/22 at 1:10pm.

Refer to telephone interview with the facility's contracted primary care provider (PCP) on 05/26/22 at 4:00pm.

_____

Interview with the Resident Care Coordinator on 05/26/22 at 1:10pm revealed there was currently no audit process to review eMAR accuracy.

Telephone interview with the facility's contracted

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D 367	Continued From page 73 primary care provider (PCP) on 05/26/22 at 4:00pm revealed she expected the facility to document on the resident's eMAR accurately because providers review the eMARs to make clinical decisions and base treatment off and it is important that it is accurate.	D 367		
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 observations, interviews, and record reviews, the facility failed to ensure residents free of neglect and received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to health care and medication administration. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up for 4 of 5 sampled residents (#1, #2, #3, and #5) in which residents' primary care providers (PCP) were not notified that medications were unavailable upon admission to the facility for administration as ordered (#1, #3, #5), referral appointments were not scheduled as ordered by the residents' PCP (#3, #5), and finger stick blood sugar (FSBS) results outside of ordered parameters were not reported (#2). [Refer to Tag	D914		

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D914	Continued From page 74 273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 5 of 5 sampled residents (#1, #2, #3, #4, #5) in which medications were unavailable for administration upon admission to the facility (#1, #3, #5), insulin and a pain reliever not administered accurately as ordered (#2), and inaccurate administration of a cholesterol (#4) and pain relieving (#1) medication. [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation)].	D914		