STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section and the Caswell County Department of Social Services conducted a follow-up survey from 09/17/19 - 09/19/19.	{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: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, record reviews and interviews, the facility failed to provide personal care assistance for nail care for 2 of 7 sampled residents (#1, #7). The findings are: 1. Review of Resident #1's current FL-2 dated 05/02/19 revealed: -Diagnoses included Alzheimer's dementia,	{D 269}		

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

hypertension, deep vein thrombosis, cardiovascular accident (stroke), and chronic obstructive pulmonary disease.
-Resident #1 resided on the special care unit (SCU).

Review of Resident #1's care plan dated 04/17/19 revealed:
-He needed assistance from staff with bathing, dressing and grooming.
-He was sometimes disoriented, forgetful and needed reminders.

Observation of Resident #1 on 09/17/19 at 10:40am revealed:
-The resident was lying on his bed resting.
-The fingernails on both of his hands were long and curved on the sides.

Interview with Resident #1 on 09/17/19 at 10:40am revealed:
-His fingernails were a little too long and needed to be trimmed.
-Staff gave him a shower and shaved him three times a week but did not trim his fingernails.

Observation of Resident #1's hands on 09/17/19 at 1:50pm revealed:
-The fingernails on his left hand measured one half to three quarters of an inch past the end of his fingers and curving on the sides; the thumb nail was starting to curve downwards.
-The fingernails on his right hand measured one half to three quarters of an inch past his fingers and curving on the sides; the thumb nail was starting to curve downwards.
-The resident's fingernails were stained yellow and had dark brown spots under the thumbnails.

Observation of Resident #1 on 09/17/19 at 2:03

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

pm revealed:
-His pointer fingernail was too long to press the button to turn off the television in his room.
-He scratched his left arm making pink marks on his forearm.

Interview with Resident #1 on 09/17/19 at 2:05pm revealed:
-He could not push the button to cut off his television because his fingernails were too long.
-He scratched his arms sometimes and made pink scratch marks on his skin.

When dressing, he would catch a fingernail in the seams of his pants, pulling the fingernail and hurting his finger.
-His fingernails were bent and starting to curl at the edges.
-His fingernails were difficult to clean under the nail and would have stained fingernails.
-Staff did not trim his fingernails when he was given his shower and shave for personal care.
-He did not remember the last time his fingernails were trimmed.
-He had not asked staff to trim his fingernails.

Review of the SCU Shower List revealed:
-Resident #1 was scheduled to have a shower on Monday, Wednesday and Friday during 2nd shift.
-Men were to be shaved on shower days.
-There were no instructions for nail care.

Interview with a first shift SCU personal care aide (PCA) on 09/18/19 at 9:03am revealed:
-The medication aides (MA)prepared the shift assignment sheets for showers and personal care.
-During a shower, residents were checked for skin breakdowns, bruises, rashes, and if fingernails and toenails needed care.

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{D 269}	Continued From page 3 -If a resident's fingernails needed to be clipped, the PCA would tell the medication aide (MA) and a PCA or MA would trim the resident's fingernails. -She had not seen Resident #1's fingernails, she was on vacation since last Thursday. Interview on 09/18/19 with the first shift SCU PCA at 9:27 am revealed: -"His finger nails are too long, they needed to be cut; he could scratch himself and start bleeding." -"For his safety, Resident #1 needs his fingernails cut." -The staff who gave him his shower a week to two weeks ago should have noticed his fingernails needed to be cut. -"If staff were doing their job, they would have seen his nails needed trimming." Interview on 09/18/19 at 4:15pm with a second shift SCU PCA revealed: -The MAs prepared the shift assignment sheets for the PCAs at the beginning of each shift. -The PCAs usually have 2-3 residents to shower and assist with personal care in an eight hour shift.. -During a resident shower, PCAs looked for bruises, skin tears, scratches and checked their fingernails to see if they need cutting and cleaning. -If a resident had long fingernails, the PCA soul trim them as part of their personal care duties. Interview on 09/18/19 with another SCU PCA at 4:30pm revealed: -The PCAs were given resident care assignments at the beginning of each shift and usually had 2-3 residents, per shift, to shower. -While bathing a resident she looked for any (skin) sores, scabs, bruises and if nail care was needed.	{D 269}		

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{D 269}	Continued From page 4 -On Monday of last week (09/09/19), Resident #1 had an incontinent bowel movement in his pull-up underwear and had fecal material under his fingernails. -She gave Resident #1 a shower and cleaned under his fingernails. -His fingernails were too long and needed clipping. -She reported the incident to the MA, telling her Resident #1's fingernails were too long. -She had not been assigned to do personal care for Resident #1 since last week and had not seen his fingernails. Interview on 09/18/19 with a SCU MA at 9:40am revealed: -PCAs were given their assignment sheets for resident care at the beginning of each shift. -PCAs were to assist residents with personal care needs, give a bath, and look for skin problems. -PCAs should also observe residents' fingernails and toenails. -If a resident's fingernails needed to be trimmed, staff were to trim the fingernails. -Male residents' fingernails were to be trimmed so the fingernails were short and neat. -Resident #1's fingernails were long and needed to be trimmed. -She was busy and it was hard to keep up with the length of residents' fingernails. Review of the SCU Work Duty assignment sheets revealed there were no personal care assignment sheets for residents for September 2019. Review of the September 2019 electronic medication administration record (e-MAR) Resident Progress Notes for Resident #1 revealed there was no documentation of nail care for the resident; the pages were blank.	{D 269}		

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{D 269}	Continued From page 5 Attempted telephone interview with Resident #1's Guardian on 09/18/19 at 3:18pm was unsuccessful. Interview on 09/18/19 with the physician's assistant (PA) at 10:00am revealed: -Resident #1's fingernails should be trimmed every other week for personal hygiene. -Bacteria would build up under his fingernails; he could get an abrasion or cellulitis of his skin from scratching himself. -He could hurt himself or others if scratched with Resident #1's long fingernails. Interview on 09/19/19 with the Director of Resident Care (DRC) at 10:35am revealed: -He was told last Monday (09/09/19) by a PCA that Resident #1's fingernails were long. -He went that day to trim the resident's fingernails, but when he tried, the resident's nails would flatten out and were difficult to cut. -The resident then refused to have his fingernails cut. -A PCA was supposed to try to cut Resident #1's fingernails later that day (0919/19). -Resident #1's fingernails were not trimmed, he did not talk with the PCA and he just forgot about getting the resident's nails trimmed. Refer to the interview with the DRC on 09/19/19 at 10:32am. Attempted interview with the Corporate Executive Director (CED) com 09/19/19 at 4:15pm was unsuccessful. 2. Review of Resident #7's current FL-2 dated 01/02/19 revealed diagnoses included diabetes, hypertension, transient ischemic attacks (brief	{D 269}		

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{D 269}	Continued From page 6 stroke-like attacks) and dysphagia (difficulty swallowing). Observation on 09/18/19 of Resident #7 at 9:05am revealed: -He was lying on his bed sleeping. -The resident had long fingernails measuring one-half of an inch long beyond his finger. -The third finger of the right hand and the thumb of the left hand had jagged edges. Interview on 09/18/19 with Resident #7 at 11:20am revealed: -No staff checked, cleaned or trimmed his fingernails, he trimmed them sometimes with his own nail clipper. -He made scratch marks on his arms before (did not remember the date) when scratching his lower arm. -He hit his fingers against the room door and make the edges jagged. -He had not asked staff to trim his nails. -He would like to have his nails trimmed and smoothed on the ends. Review of the AL Shower List revealed: -Resident #7 was scheduled to have a shower on 3rd shift Monday, Wednesday, and Friday. -Men were to be shaved on shower days. -There were no instructions to do or check-off resident nail care. Interview on 09/18/19 at 11:30am with a first shift AL personal care aide (PCA) revealed: -Resident #7 was scheduled to take a shower on Monday, Wednesday and Friday on third shift, usually about 6:30 am. -PCAs checked the residents for bruises on the skin, swelling, fingernails and toenails. -If a residents' fingernails were long, he could get	{D 269}		

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{D 269}	Continued From page 7	{D 269}		

an infection from germs and dirt under the nails.
-A resident could scratch themselves and the PCAs during personal care.
-She had not given Resident #7 a shower; she had not noticed his fingernails were long.

Interview on 09/19/19 with a first shift medication aide (MA) at 11:40am revealed:
-She noticed residents' fingernails while administering medications when they reach for the cup holding the medications.
-When assisting with residents' showers, the PCAs should look for any redness, skin tears, dry skin rashes and check fingernails and toenails.
-If a PCA noticed a resident's nails needed trimming, the PCA should give a report to the MA or the Director of Resident Care (DRC) and the MA would trim the resident's fingernails.
-There was no PCA documentation on the Work Dotty Sheet that Resident #7 had long fingernails.
- There was no documentation the PCA responsible for Resident #7's care told the DRC that the resident had long fingernails.

Review of Resident #7's electronic medication administration record (e-MAR) Progress Notes for July 2019 and September 2019 (August 2019 notes were not available) revealed there was no documentation of nail care for Resident #7.

Interview on 09/19/19 with the physician's assistant (PA) at 12:05pm revealed:
-He was not aware Resident #7 had long fingernails.
-The resident had diabetes and could have a skin infection from the build-up of bacteria under his nails or an abrasion from scratching himself.
-Resident #7 needed to have his fingernails trimmed every other week for personal hygiene.

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{D 269}	Continued From page 8 Interview on 09/19/10 with the DRC at 12:10pm revealed: -He trimmed Resident #7's fingernails one month ago, about the third week in August 2019. -He had not checked Resident #7's fingernails since August 2019. -No staff reported Resident #7"s fingernails were long. -There was no schedule for personal nail care for residents; staff were to document resident information in the progress notes. -He should have checked back about Resident #7's fingernails. -He needed to check on Resident #7's fingernails every week. Refer to the interview with the DRC on 09/09/19 at 10:32am. _____ Interview on 09/19/19 with the DRC at 10:32 am revealed: -When the PCA's gave showers, or a bath, they should look for skin conditions, bruises, skin tears, dried blood, any injury, check fingernails and toenails. -If a resident had a skin concern or long fingernails, the PCA should notify the MA or the DRC. -A resident having long fingernails could scratch themselves or other residents, dirt and food could accumulate under the fingernails and cause an infection. -If a PCA was concerned about a resident having long fingernails, they should trim their nails as part of the resident's personal care. -There was not a system in place for documenting residents' personal nail care. _____ The facility failed to provide personal care assistance with nail care for Resident #1 who had	{D 269}		

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{D 269}	Continued From page 9 stained long curling fingernails and pink marks on his arms from scratching and Resident #7 who had diabetes and had long fingernails with jagged edges. The facility's failure increased the risk of infection and skin breakdown which was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/19/19 for this violation.	{D 269}		
{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: Based on observations, interviews and record reviews, the facility failed to notify the endocrinologist for 2 of 6 residents sampled, related to coordinating care with the endocrinologist and not notifying the endocrinologist of missed doses of an injection for diabetes prescribed by the endocrinologist (#6); and a resident who had elevated blood sugars outside of the ordered parameter (#3). The findings are:	{D 273}		

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{D 273}	Continued From page 10 Review of Resident #6's current FL-2 dated 03/13/19 revealed diagnoses included diabetes mellitus, developmental disorder and intellectual disability. Review of an after-visit summary from Resident #6's endocrinologist dated 04/23/19 revealed an order for Trulicity 1.5mg/0.5ml, inject 1.5 mg under the skin once a week. (Trulicity is used to treat type 2 diabetes.) Review of an after-visit summary from Resident #6's endocrinologist dated 05/14/19 revealed an order for Trulicity 0.75mg weekly. Review of an order dated 07/31/19 from Resident #6's primary care provider (PCP) revealed an order for Trulicity 0.75mg/0.5ml once weekly. Review of a prescription from Resident #6's endocrinologist dated 09/03/19 revealed an order for Trulicity 1.5mg/0.5ml, inject 1.5mg under the skin once a week. Review of Resident #6's electronic medication administration records (e-MAR) for April 2019 revealed: -There was no entry for Trulicity on the April 2019 e-MAR. -Resident #6's blood sugar was obtained four times daily and ranged from 93-400. Review of Resident #6's e-MAR for May 2019 revealed: -There was no entry for Trulicity on the May 2019 e-MAR. -Resident #6's blood sugar was obtained four times daily and ranged from 147-411.	{D 273}		

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{D 273}	Continued From page 11 Review of Resident #6's e-MAR for June 2019 revealed: -There was no entry for Trulicity on the June 2019 e-MAR. -Resident #6's blood sugar was obtained four times daily and ranged from 137-400. Review of Resident #6's e-MAR for July 2019 revealed: -There was no entry for Trulicity on the July 2019 e-MAR. -Resident #6's blood sugar was obtained four times daily and ranged from 119-382. Review of Resident #6's e-MAR for August 2019 revealed: -There was an entry for Trulicity 0.75mg/0.5ml, inject once weekly. -There was a start date of 08/07/19 and an end date of 09/03/19 by the entry. -Trulicity was documented as administered on 08/27/19, which was a Tuesday. -There was no documentation Trulicity was administered any other dates in August 2019. -Resident #6's blood sugar was obtained four times daily and ranged from 147-411. Review of Resident #6's e-MAR for September 2019 revealed: -There was an entry for Trulicity 0.75mg/0.5ml, inject once weekly. -There was a start date of 08/07/19 and an end date of 09/03/19 by the entry. -Trulicity was documented as administered on 09/03/19. -There was no documentation Trulicity was administered any other dates in September 2019. -Resident #6's blood sugar was obtained four times daily from 09/01/19-09/17/19 and ranged from 121-500.	{D 273}		

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{D 273}	Continued From page 12 Observation of medications on hand for Resident #6 on 09/19/19 at 10:50am revealed there were two unopened Trulicity 1.5mg/0.5ml pens with a dispense date of 04/22/19. Telephone interview with a representative from the facility's contracted pharmacy on 09/19/19 at 8:30am revealed: -There was an order for Trulicity 1.5mg weekly received on 03/31/19 for Resident #6. -Two pens were last dispensed on 04/22/19, which was a two-week supply. -Another order was received on 09/03/19, and Resident #6's insurance denied paying for the Trulicity when the pharmacy tried to dispense the medication to the facility. Prior to that date, his insurance had covered the injection. -The pharmacist notified the facility staff via fax on 09/03/19 Resident #6's insurance rejected Trulicity; the facility staff were responsible for notifying the provider. -Trulicity was not on cycle fill; staff would have to request it be refilled. Interview with a medication aide (MA) on 09/19/19 at 10:50am revealed: -She did not know why the two Trulicity pens for Resident #6, dispensed in April 2019, remained in the refrigerator. -She was not aware of an issue with his insurance rejecting the injection. -Trulicity was not "popping up" on the e-MAR for her to administer today, 09/19/19. -There was nothing in the progress notes regarding Trulicity. -Trulicity was not on cycle fill and had to be reordered by the MAs. Review of Resident #6's electronic progress	{D 273}		

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notes revealed there was no documentation about Trulicity being unavailable to administer.

Interview with the Resident Care Director (RCD) on 09/19/19 at 11:10am revealed:
-He was not aware of an issue with Resident #6's Trulicity.
-He was not aware of the insurance rejecting Trulicity.
-The order for Trulicity was showing discontinued in the computer system.
-He did not know what happened with Resident #6's Trulicity, but he, the Resident Care Coordinator (RCC) or the Memory Care Manager (MCM) should check the orders received against what the pharmacy staff entered for accuracy.

Review of a faxed message from the pharmacist at the facility's contracted pharmacy regarding Resident #6's Trulicity dated 09/05/19 revealed:
-The pharmacy had received new hard copy prescriptions on 09/03/19 from a clinical pharmacist, who worked with Resident #6's endocrinologist.
-Because the clinical pharmacist was not registered with the resident's insurance company as a provider, the insurance was not processing the order.
-Please obtain orders from a different provider with the new doses.
-Attached to this faxed message were two confirmation sheets from the RCC to Resident #6's primary care provider (PCP) dated 09/05/19 and 09/19/19; under the comments, "please fax back" was written.

Review of the return fax message dated 09/19/19 from Resident #6's PCP revealed and order for Trulicity 1.5mg weekly; "prescriptions sent to pharmacy" was handwritten on the faxed

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{D 273}	Continued From page 14 message. Interview with the RCC on 09/19/19 at 2:30pm revealed: -There was no need to send the notification from the pharmacy to Resident #6's endocrinologist. -The note from the pharmacy stated to send to the PCP. -The staff contacted the PCP for everything, even though Resident #6's endocrinologist ordered the Trulicity injection. Second Interview with the RCD on 09/19/19 at 2:30pm revealed: -The staff contacted Resident #6's PCP for everything, because it was "just easier" since the PCP was local. -The MAs wanted the RCD, RCC or MCM to contact the providers for order clarifications or any questions about orders. -It would be better for the MAs to obtain clarification of orders from the provider, or contact the providers with any concerns about orders, since the MAs knew what the issue was. -Staff, including the RCC, RCD or MCM, "probably" did not look at the prescriptions every time and compare the orders with what pharmacy staff entered onto the e-MAR. -The RCD, RCC or MCM audited the medication carts every week; they looked at every medication in the carts to ensure orders were being followed and medications being administered were documented on the e-MAR. -Medications were delivered from the pharmacy every day, sometimes multiple times per day. Interview with the Business Office Manager upon entrance to the facility on 09/17/19 at 9:30am revealed: -She would be the contact person.	{D 273}		

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{D 273}	Continued From page 15 -The Executive Director for the facility would not be available for interview. Telephone interview with the nurse at Resident #6's endocrinologist's office on 09/19/19 at 8:00am revealed: -Resident #6's Trulicity was originally ordered for 1.5mg weekly in April 2019, but the order was decreased to 0.75mg weekly in May 2019; it was increased again to 1.5mg weekly on 09/03/19 because after looking at the hemoglobin A1C, it appeared his diabetes was not managed, so the dose was increased. -The resident had not been getting the maximum dose when he was receiving 0.75mg. -Staff should be calling their office if there was an issue with getting Trulicity that could result in a missed dose. -The endocrinologist was not aware Resident #6 had not been receiving Trulicity as ordered or that there was an issue with insurance payment. -It was concerning that Resident #6, who was developmentally disabled, was not being monitored any better by staff; the resident was reliant on staff to monitor his medications and blood sugars. Attempted telephone interview with Resident #6's primary care provider on 09/19/19 at 12:30pm was unsuccessful. 2. Review of Resident #3's current FL-2 dated 01/31/19 revealed diagnoses included schizophrenia, personality disorder, bipolar mood disorder, diabetes mellitus, hypertension, hypothyroidism, gastroesophageal reflux disease, and irritable bowel syndrome. Review of Resident #3's endocrinologist orders revealed there was an order dated 08/14/19 for	{D 273}		

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{D 273}	Continued From page 16 Novolog insulin 15 units and sliding scale insulin before meals. (Novolog is used to lower blood glucose levels). Review of the Blood Glucose Monitoring and Insulin Dosing Guide from Resident #3's 08/14/19 endocrinologist appointment revealed instructions to call the endocrinologist's office if blood sugar was above 300 for three tests in a row or to call the hospital if it was after 5:00pm or on the weekend. Review of Resident #3's August 2019 electronic medication administration record (e-MAR) revealed: -There was an entry to obtain blood sugars before meals and at bedtime, 7:00am, 11:00am, 4:00pm, and 8:00pm. -On 08/16/19, blood sugar was documented as 509 at 11:00am. -On 08/16/19, blood sugar was documented as 446 at 4:00pm. -On 08/16/19, blood sugar was documented as 527 at 8:00pm. -There was no entry the endocrinologist or hospital had been contacted. -On 08/20/19, blood sugar was documented as 368 at 7:00am. -On 08/20/19, blood sugar was documented as 368 at 11:00am. -On 08/20/19, blood sugar was documented as High at 4:00pm. -There was no entry the endocrinologist or hospital had been contacted. -On 08/20/19, blood sugar was documented as High at 8:00pm. -There was no entry the endocrinologist or hospital had been contacted. -On 08/22/19, blood sugar was documented as 350 at 11:00am.	{D 273}		

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{D 273}	Continued From page 17 -On 08/22/19, blood sugar was documented as 360 at 4:00pm. -On 08/22/19, blood sugar was documented as 366 at 8:00pm. -There was no entry the endocrinologist or hospital had been contacted. -On 08/23/19, blood sugar was documented as 461 at 7:00am. -There was no entry the endocrinologist or hospital had been contacted. -On 08/23/19, blood sugar was documented as 464 at 11:00am. -There was no entry the endocrinologist or hospital had been contacted. Review of Resident #3's September 2019 eMAR revealed: -There was an entry to obtain blood sugars before meals and at bedtime, 7:00am, 11:00am, 4:00pm, and 8:00pm. -On 09/08/19, blood sugar was documented as 431 at 11:00am. -On 09/08/19, blood sugar was documented as 383 at 4:00pm. -On 09/08/19, blood sugar was documented as 455 at 8:00pm. -There was no entry the endocrinologist or hospital had been contacted. -On 09/14/19, blood sugar was documented as 344 at 7:00am. -On 09/14/19, blood sugar was documented as 344 at 11:00am. -On 09/14/19, blood sugar was documented as High at 4:00pm. -There was no entry the endocrinologist or hospital had been contacted. -On 09/14/19, blood sugar was documented as 315 at 8:00pm. -There was no entry the endocrinologist or hospital had been contacted.	{D 273}		

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{D 273}	Continued From page 18 Interview with the Resident Care Director (RCD) on 09/19/19 revealed: -The protocol was to call the endocrinologist for instruction on insulin coverage when the glucometer reported blood sugar as "High." Review of Resident #3's progress notes revealed there was no documentation the endocrinologist or hospital was notified of the blood sugars greater than 300 for three consecutive readings. Attempted telephone interview with Resident #3's endocrinologist on 09/19/19 at 7:45am and 2:30pm was unsuccessful.	{D 273}		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure orders for finger stick	D 276		

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blood sugar (FSBS) checks were completed as ordered for 1 of 2 sampled residents (#6).

The findings are:

Review of Resident #6's current FL-2 dated 03/13/19 revealed diagnoses included diabetes mellitus, hypertension, developmental disorder and intellectual disability.

Review of physician's orders (6 months orders) for Resident #6 dated 07/31/19 revealed:
-There was an order to recheck FSBS one hour after Humalog was administered and call the physician if the FSBS was greater than 500. (Humalog is a fast-acting insulin used to lower blood glucose levels.)
-There was a second order to check FSBS before meals and at bedtime.
-There was a medication order for Humalog insulin per sliding scale three times daily before meals as follows: 200-250 = 5 units; 251-300 = 10 units; 301-350 = 15 units; 351-400 = 20 units; greater than 400, call physician.

Review of a physician's order from Resident #6's endocrinologist dated 08/13/19 revealed a medication order to increase Humalog sliding scale insulin as follows: 200-250 = 8 units; 251-300 = 13 units; 301-350 = 18 units; 351-400 = 23 units; greater than 400, call physician.

Review of Resident #6's electronic medication administration records (e-MAR) for July 2019 revealed:
-There was an entry for Humalog per sliding scale three times daily before meals: 200-250 = 5 units; 251-300 = 10 units; 301-350 = 15 units; 351-400 = 20 units; greater than 400, call physician, scheduled for administration at 7:00am, 12:00

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noon and 5:00pm.
-There was documentation Resident #6 received Humalog insulin 68 opportunities in July 2019.
-There was an entry that read when Humalog was administered recheck FSBSone hour later and call physician if FSBS greater than 500.
-There was no documentation Resident #6's FSBS was rechecked after receiving Humalog insulin.
-Resident #6's blood sugars ranged from 119-393 in July 2019.

Review of Resident #6's e-MAR for August 2019 revealed:
-There was an entry for Humalog per sliding scale three times daily before meals: 200-250 = 5 units; 251-300 = 10 units; 301-350 = 15 units; 351-400 = 20 units; greater than 400, call physician.; this entry had an end date of 08/15/19.
-There was a second entry for Humalog per sliding scale three times daily before meals: 200-250 = 8 units; 251-300 = 13 units; 301-350 = 18 units; 351-400 = 23 units; greater than 400, call physician, scheduled for administration at 7:00am, 12:00 noon and 5:00pm.
-There was documentation Resident #6 received Humalog insulin 72 opportunities in August 2019.
-There was an entry that read when Humalog was administered recheck FSBS one hour later and call physician if blood sugar greater than 500.
-There was no documentation Resident #6's FSBS was rechecked after receiving Humalog insulin.
-Resident #6's FSBS ranged from 120-433 in August 2019.

Review of Resident #6's e-MAR for September 2019 revealed:
-There was an entry for Humalog per sliding scale three times daily before meals: 200-250 = 8 units;

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D 276	Continued From page 21 251-300 = 13 units; 301-350 = 18 units; 351-400 = 23 units; greater than 400, call physician, scheduled for 7:00am, 11:00am and 4:00pm. -There was documentation Resident #6 received Humalog insulin 40 opportunities from 09/01/19-09/17/19. -There was an entry that read when Humalog was administered recheck FSBS one hour later and call physician if FSBS greater than 500. -There was no documentation Resident #6's FSBS was rechecked after receiving Humalog insulin. -Resident #6's FSBS ranged from 121-500 in September 2019. Observation of the 4:30pm medication pass on 09/17/19 at 3:45pm revealed: -The medication aide (MA) obtained Resident #6's FSBS (result was 221) at 3:45pm. -The MA administered Humalog insulin (8 units) based on the sliding scale at 3:49pm. Interview with the MA on 09/17/19 at 4:49pm revealed: -She had not rechecked Resident #6's FSBS after giving him Humalog insulin at 3:49pm. -She was not aware there was an order to recheck Resident #6's FSBS one hour after Humalog administration. Observation of the MA obtaining Resident #6's FSBS at 5:10pm revealed Resident #6's FSBS was 197. Second interview with a MA on 09/17/19 at 5:04pm revealed: -She thought she was to recheck Resident #6's FSBS in one hour if the FSBS was greater than 500 when the sliding scale insulin was administered.	D 276		

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-The MA had never seen the order to recheck the FSBS in one hour after Humalog was administered "pop-up" on the e-MAR.

Interview with another MA on 9/17/19 at 5:06pm revealed:
-She did not work that medication cart often but had never seen the order on the e-MAR for her to recheck Resident #6's FSBS in one hour after Humalog was administered.
- "I just don't know."
-The FSBS rechecks should be documented on the e-MAR or in the progress notes depending on how management set up the entry in the e-MAR.
-The MA deferred information regarding the order to the memory care manager (MCM).

Interview with the MCM on 09/17/19 at 5:10pm revealed based on the order entered onto the e-MAR, the MAs should recheck the FSBS in one hour if Humalog was given according to the sliding scale.

Interview with the Resident Care Director (RCD) on 09/18/19 at 3:38pm revealed:
-The MAs reported to him when the FSBS was greater than 400.
-He would advise the MAs to recheck the FSBS after giving any sliding scale insulin.
-FSBS that were rechecked would be documented in the progress notes or on the vital signs sheet.

Review of electronic progress notes for Resident #6 revealed there were no entries regarding FSBS being rechecked one hour after Humalog administration.

Interviews with Resident #6 on 09/19/18 at 9:25am and 4:00pm revealed:

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D 276	Continued From page 23 -Staff checked his blood sugar, but he was not sure how often. -He knew he got "a shot a lot because it pinched" when staff administered it. Second interview with the RCD on 09/19/19 at 11:10am revealed: -He, the Resident Care Coordinator (RCC) or MCM approved orders entered by the pharmacy staff. -The pharmacy did not enter the recheck order after Humalog was administered, so the entry did not appear on the e-MAR for the MAs to recheck. Interview with the Business Office Manager upon entrance to the facility on 09/17/19 at 9:30am revealed: -She would be the contact person. -The Executive Director for the facility would not be available for interview. Telephone interview with the nurse at Resident #6's endocrinologist's office on 09/19/19 at 8:00am revealed: -Staff should be rechecking Resident #6's FSBS in one hour after administering Humalog sliding scale insulin. -Staff should call the endocrinologist's office if the FSBS was greater than 500 at that time. -The endocrinologist was not aware Resident #6 had not been having his FSBS rechecked after receiving Humalog.	D 276		
{D 282}	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes:	{D 282}		

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{D 282}	Continued From page 24 (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure the kitchen was protected from contamination by evidence of missing dates and labels on food, as evidenced uncovered food in the refrigerators, no paper towels at the handwashing sink, scoops stored inside of bulk food containers and buildup on the hot food serving table. The findings are: Review of the most current NC Division Environment Health sanitation report dated 01/15/19 revealed the inspection report indicated there were no paper towels available at the hand sink at the time of the inspection. Observation of the reach-in refrigerator on 09/17/19 at 1:59pm revealed: -There was an opened package of mozzarella cheese that did not have a date or a label. -There was an opened package of sliced American cheese that did not have a date or a label. -There was an opened package of sliced turkey that did not have a date or a label. -There was a container that had melted margarine that did not have a date or a label. -There was a half of a case of thawed nutritional shakes with a delivery date of 07/18/19. Observation of the walk-in refrigerator on 09/17/19 at 2:45pm revealed: -There was a one pound of package of cream	{D 282}		

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{D 282}	Continued From page 25 cheese that was unwrapped in a box without a lid, the cream cheese was not dated. -There were two ten pound tubes of beef that were unopened in a pan and not dated. Observation of the kitchen on 09/17/19 at 2:24pm revealed: -There was dicolored water with food particles in the hot holding wells of the hot food service table. -There was a buildup of yellow and brown scales in the inside of the hot holding wells of hot food serving table. -There was a broken paper towel dispenser at the only handwashing sink in the kitchen; the paper towels were on a prep table three feet away from the sink. -There was a scoop stored inside of a bulk container of granulated sugar. Observation of the dry storage area on 09/17/19 at 2:20pm revealed: -There was a scoop stored inside a bulk container of brown sugar. -There was a plastic cup stored inside a bulk container of food thickener. Review of the kitchen cleaning list on 09/17/19 at 2:30pm revealed: -There were daily, weekly and monthly cleaning schedules in a three-ring binder on a shelf in the kitchen. -The hot food serving table was listed on the daily cleaning schedule dated 09/16/19 and 09/17/19 and initialed as "cleaned and sanitized after use". -The hot food serving table was not listed on the weekly or monthly cleaning schedules. Interview with the cook on 09/17/19 at 1:59pm revealed: -The paper towel dispenser had been broken for	{D 282}		

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a couple of days; the Kitchen Manager knew the dispenser was broken.
-The hot food serving table was wiped clean and the water in the hot holding wells was changed daily.
-The pans that held the water inside the holding wells were removed and cleaned once a week.
-The pans for the water were only cleaned when they looked dirty; he would remove the pans and take them to the pot and pan sink to scrub them clean.
-He had used a degreaser cleanser and scrubbed the pans but could not remove the brown build up in the pans.
-He dated food after he used it and before he placed food back into the refrigerator.

Interview with the Kitchen Manager on 09/17/19 at 2:20pm revealed:
-All food items were dated when opened and at the end of the day.
-He checked the refrigerators and dry storage area in the mornings and in the evenings to make sure everything was dated.
-Left over food was discarded seven days after the handwritten date on the label; food stored in the manufacture's package were not discarded until the manufacture's expiration date.
-He was not sure how long the supplement shakes could be kept after thawing; the supplement shakes had been in the reach-in refrigerator since they were delivered on 07/18/19.
-The cream cheese should have been wrapped and not left open when stored.
-The ground beef in the walk-in refrigerator was to be used the next day for the lunch menu; he did not know it needed to be dated and labeled.
-The hot holding wells in the hot food serving table were not on the daily cleaning list but, the

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{D 282}	Continued From page 27 serving table was cleaned at the end of the day; the water was removed, and the surface was wiped cleaned daily. -The pans that held the water int hot holding wells were scrubbed three to four times a week but, the brown and yellow build up could not be removed. -The paper towel dispenser at the hand sink had been broken since 08/01/19; the Executive Director had ordered a replacement dispenser in August 2019. -The kitchen staff had been verbally told not to store scoops inside of bulk food containers; he did not conduct weekly or monthly in-services or meetings to instruct the kitchen staff. Interview with the maintenance technician on 09/18/19 at 4:38pm revealed: -The paper towel dispenser for the kitchen had been ordered about a week and a half ago; that was the first time the broken dispenser had been brought to his attention. -He usually had a new dispenser on hand, but he had used the last one and did not know. -He had never ordered a paper towel dispenser, so he did not know how long it took for the dispenser to be delivered after one was ordered. The Executive Director was not available for interviewes. Interview with the Kitchen Manager on 09/17/19 at 2:45pm revealed he could not remember the last time the cream cheese was used.	{D 282}		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service	D 286		

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D 286	Continued From page 28 (b) Food Preparation and Service in Adult Care Homes: (1) Sufficient staff, space and equipment shall be provided for safe and sanitary food storage, preparation and service. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to assure the walk-in freezer was maintained at the proper temperature range. The findings are: Observation of the walk-in freezer on 09/17/19 at 2:30pm revealed: -The thermometer on the outside of the walk-in freezer read 20 degrees F. -There were four thermometers on the shelves in the inside of the walk-in freezer and the readings ranged from 18 degrees F to 20 degrees F. -There were 2 half gallon cartons of ice cream that were soft when touched. -There was a build up of ice on the floor. Review of the walk-in freezer temperature log for July 2019 on 09/17/19 at 2:30pm revealed: -There were thirty-one dates on the log and a daily temperature documented for AM (morning) and PM (evening). -The lowest morning temperature documented was 17 degrees F and the highest morning temperature documented was 21 degrees F. -The lowest evening temperature documented was 17 degrees F and the highest evening temperature documented was 22 degrees F. -There were no signatures or initials on the log. -There were no parameters for freezer temperatures on the log.	D 286		

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D 286	Continued From page 29 Review of the walk-in freezer temperature log for August 2019 on 09/17/19 at 2:30pm revealed: -There were thirty-one dates for documenting temperatures for morning and evenings. -There were sixty-two opportunities to document temperatures and twenty-two times temperatures were not documented. -The lowest morning temperature documented was 18 degrees F and the highest morning temperature documented was 21 degrees F. -The lowest evening temperature documented was 18 degrees F and the highest evening temperature documented was 22 degrees F. -There were initials for each temperature documented. -There were no parameters for freezer temperatures on the log. Review of the walk-in freezer temperature log for September 2019 on 09/17/19 at 2:30pm revealed: -There were thirty dates available for documenting temperatures for morning and evenings. -The parameters listed for the freezer temperatures were -10 degrees F to 0 degrees F. -There were initials beside each documented temperature. -The lowest morning temperature documented was 19 degrees F and the highest morning temperature documented was 20 degrees F. -The lowest evening temperature documented was 18 degrees F and the highest evening temperature documented was 22 degrees F. Interview with the cook on 09/19/19 at 4:02pm revealed: -He documented on the temperature log for the walk-in freezer when he worked. -He knew the walk-in freezer temperature was supposed to be -10 degrees F to 0 degrees F.	D 286		

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D 286	Continued From page 30 -He reported to the Kitchen Manager whenever he saw the temperature on the walk-in freezer was above 0 degrees F. -He could not remember when the temperature of the walk-in freezer was first above 0 degrees F, he thought it was a couple of months ago. -He used one of the inside thermometers to take the temperatures for the temperature log sheet. Interview with the Kitchen Manager on 09/17/19 at 2:30pm revealed: -He knew the temperature of the freezer was 20 degrees F. -He printed a temperature log from the internet for the kitchen staff to document the temperatures for the walk-in freezer. -He saw the parameters for freezer temperatures on the temperature log he had printed, but he thought different freezers had different temperature requirements. -He had a current food safety certification. Interview with the maintenance technician on 09/18/19 at 4:33pm revealed: -The Kitchen Manager would let him know when any kitchen equipment was not working properly; he would do the repair work himself or call for an outside company to do the repair. -He cleaned the coils on the freezer at the end of every month, but he did not keep a log. -The Kitchen Manager is responsible for monitoring the temperature of the walk-in freezer and reporting any concerns to the maintenance technician. -The Kitchen Manager did not let him know there was an issue with the temperature for the walk-in freezer. -He had been the maintenance technician for one year and ten months and there were no problems with the freezer in the time he had been the	D 286		

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D 286	Continued From page 31 maintenance technician. -He had cleaned the coils yesterday, 09/17/19 after he was told the freezer was not at the correct temperature. -He had checked the walk-in freezer temperature on 09/18/19 at 6:00am and the reading was minus 8 degrees F. Observation of the walk-in freezer on 09/19/19 at 11:40am revealed the temperature on the thermometer inside the walk-in freezer was 0 degrees F.	D 286		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify the order and serve 1 of 6 residents sampled (#3) the diet as ordered by her physician. The findings are: Review of Resident #3's current FL-2 dated 01/31/19 revealed: -Diagnoses included schizophrenia, personality disorder, bipolar mood disorder, diabetes mellitus, hypertension, hypothyroidism, gastroesophageal reflux disease, and irritable bowel syndrome.	D 296		

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D 296	Continued From page 32 -There was an order for no added table salt (NATS), diabetic diet. Review of Resident #3's primary care provider (PCP) orders revealed: -There was an order dated 07/11/19 for a NATS, mechanical soft with chopped meats diet. -There was a hospital discharge summary dated 07/24/19 with instructions for a low sodium heart healthy diet and to follow a heart healthy and modified carbohydrates diet. -The discharge summary was signed and dated by the resident's PCP on 07/25/19. Observation of the dinner meal on 09/17/19 revealed: -Resident #3 used salt to season her dinner. -There were opened salt packets to the right of her dinner plate. Interview with Resident #3's PCP on 09/19/19 at 10:05am revealed: -The facility did not offer a low sodium heart healthy diet. -There should have been an order in the record resuming the NATS, chopped meats diet. Interview with the Resident Care Director (RCD) on 09/19/19 at 10:45am revealed: -Discharge instructions were "not really orders." -Discharge instructions were reviewed by the PCP. -The facility did not offer a low sodium heart healthy diet.	D 296		
{D 310}	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service	{D 310}		

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{D 310}	Continued From page 33 (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to assure therapeutic diets were served as ordered for 3 of 7 sampled residents with diet orders for pureed diet (Resident #7), a mechanical soft diet with nectar thick liquids (Resident #4) and a mechanical soft diet (Resident #3). The findings are: 1. Review of Resident #7's current FL-2 dated 01/02/19 revealed: -Diagnoses included diabetes mellitus type two, hypertension, stroke, transient ischemic attack, hyperlipidemia and dysphagia. -There was an order for a mechanical soft chopped diet. Review of Resident #7's physician signed diet order dated 09/12/19 revealed an order for a pureed diet designed to provide foods of a smooth, soft consistency, like fluffy, whipped potatoes. Review of the therapeutic diet list in the kitchen on 09/17/19 revealed Resident #7 was to be served a pureed diet. Review of the therapeutic diet menu for a pureed diet on 09/17/19 for the dinner meal revealed pureed blackened chicken, pureed lemon rice	{D 310}		

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{D 310}	Continued From page 34 and pureed lima beans were to be served. Observation of the dinner meal on 09/17/19 at 5:36pm revealed: -Resident #7 was served chicken, rice and lima beans on a divided plate. -The chicken was dry, thick and had a grainy texture; it was not smooth and did not have a fluffy whipped potato consistency. -There was no gravy or sauce on the chicken. -The rice was grainy and not a fluffy, whipped potato consistency. -The lima beans were not smooth but had small lumps and very thin in consistency; they were not a fluffy, whipped potato consistency. -Resident #7 took a bite of the pureed chicken and began to cough and then proceeded to vomit. -Resident #7 left the dining room. Observation of the dinner meal on 09/17/19 at 5:43pm revealed: -Resident #7 came back to the dining room and returned to his seat. -A staff asked him if he wanted a second plate of food and he said yes. -Resident #7 was served on a divided plate; pureed chicken, pureed rice and pureed lima beans, all of which had the consistency of cream soup. -Resident #7 refused to eat the meal and asked for a cup of yogurt. -The staff brought him two cups of yogurt; he began to eat the first cup and proceeded to vomit again. -After a few more attempts at eating Resident #7 was able to eat a cup of yogurt and a cup of ice cream. Observation of the dining room on 09/18/19 at 8:15am revealed:	{D 310}		

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{D 310}	Continued From page 35 -Resident #7 was served pureed eggs, pureed hash brown potatoes and applesauce. -Resident #7 ate 100% of the eggs and 100% of the applesauce; he did not eat the hash brown potatoes. -The pureed eggs were smooth and fluffy whipped potato consistency; the hash brown potatoes were dry and not smooth and fluffy. Interview with Resident #7 on 09/18/19 at 8:30am revealed the eggs and the applesauce were good, but the potatoes were too thick to eat; he got enough to eat. Observation of the Kitchen Manager on 09/18/19 at 12:37pm revealed: -He took a hamburger bun, a hamburger patty and a slice of American cheese and placed it into a food processor. -The added warm water and blended the contents together in the food processor. -He poured the pureed hamburger into a divided plate; the puree hamburger was the consistency of a cream soup and had bits of cheese visible in it. -He placed a handful of French-fried potatoes into the food processor with warm water and blended the contents together. -The potatoes were thick and sticky; they were not smooth and fluffy. Interview with Resident #7 on 09/17/19 at 5:43pm revealed: -He choked when he ate the pureed chicken because it was too dry. -He choked and threw up when the pureed food was too dry. -He felt the food hit the back of his throat and then he threw up. -He did not throw up when he drank his	{D 310}		

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{D 310}	Continued From page 36 beverages, only when he tried to eat. Interview with Resident #7 on 09/19/19 at 11:00am revealed: -Sometimes the pureed food was too dry and sometimes it was too runny and cold. -He seemed to throw up his food when the puree was too dry or too runny. -It seemed like his food was "never right". -He eats a lot of yogurt, ice cream and applesauce; he was not hungry because he got enough to eat. Interview with a personal care aide (PCA) on 09/19/19 at 11:16am revealed: -Resident #7 had vomited a couple of months ago while eating in the dining room but, it had not happened since then. -Resident #7 would cough while eating at every meal but it did not always lead to him vomiting. -Resident #7 is on a pureed diet so the food is almost a liquid. Interview with the Activities Director on 09/19/19 at 11:15am revealed: -She helped serve residents in the dining room at lunch time. -She had seen Resident #7 vomit while eating his meal; she had witnessed Resident #7 vomit recently but could not remember the exact date. -She never heard him cough while eating. -The facility staff knew Resident #7 vomited when eating his meals; "that is why he was on a pureed diet". Interview with a medication aide (MA) on 09/19/19 at 2:28pm revealed: -She did not help in the dining room every day; only when she had time to help. -She saw Resident #7 vomit in the dining room	{D 310}		

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{D 310}	Continued From page 37 during the dinner meal on 09/17/19; the last time she had seen him vomit in the dining room was sometime in May 2019. Telephone interview with the Speech Therapist on 09/19/19 at 10:41am revealed: -She had worked with Resident #7 for swallowing difficulties and had taught him oral motor exercises; the goal was to strengthen Resident #7's swallowing. -There were periods where Resident #7 would be okay and not vomit at his meals. -She had tried to upgrade Resident #7's diet from a pureed diet to a MS diet but he needed to stay on the pureed diet due to the difficulty with swallowing. -She did not witness his coughing, choking or vomiting but was told by facility staff he vomited when he ate his food before she had worked with him; he had completed his therapy. -She had not been contacted by facility staff or the physician with any concerns about Resident #7 since he had completed his therapy in March 2019. Interview with Resident #7's primary care physician (PCP) on 09/19/19 at 10:18am revealed: -Resident #7 had a history of vomiting while eating due to swallowing difficulties. -Resident #7 had worked with a speech therapist to improve swallowing techniques and was on a pureed diet. -There were no concerns with Resident #7's weight; Resident #7 had not vomited while eating for several months. -He was concerned Resident #7 had vomited at a recent meal; the facility staff had not informed him.	{D 310}		

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{D 310}	Continued From page 38 Refer to interview with the cook on 09/19/19 at 4:02pm. Refer to interview with the Kitchen Manager on 09/18/19 at 9:54am. Refer to interview with the Resident Care Director (RCD) on 09/19/19 at 2:31pm. The Administrator was not available for interviews. 2. Review of Resident #4's current FL-2 dated 03/13/19 revealed: -Diagnoses included leukocytosis, depression, hypertension, history of breast cancer, neuropathy, glaucoma, constipation and gastroesophageal reflux disease. -There was a physician's order for Mechanical Soft diet with nectar thick liquids. Review of a subsequent physician's order dated 07/08/19 revealed: -There was a diet order for Regular, Mechanical Soft (entire meal) and thickened liquids. -There was no consistency indicated on the order for thickened liquids. Review of Resident #4's resident register dated 10/29/15 revealed Resident #4 was lactose intolerant. Review of the therapeutic diet list in the kitchen on 09/17/19 revealed Resident #4 was to be served a mechanical soft diet and nectar thick liquids. Review of the therapeutic diet menu for the dinner meal on 09/17/19 revealed chopped blacken chicken with a sauce, lemon rice, lima	{D 310}		

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{D 310}	Continued From page 39 beans and soaked cornbread were to be served. Observation of the dinner meal on 09/17/19 at 5:32pm revealed Resident #4 was served a square piece of cornbread that she picked up with her fingers and ate; the piece of cornbread was not soaked with a liquid before it was served to Resident #4. Review of the therapeutic diet menu for the lunch meal on 09/17/19 revealed chopped meat, yellow squash with onions, and a mechanical soft cookie were to be served. Observation of the lunch meal on 09/18/19 at 12:38pm revealed Resident #4 was served a hamburger on a bun that was cut into eight pie shaped wedges, chopped lettuce, French fries and a hard cookie. Interview with Resident #4 on 09/18/19 at 1:10pm revealed: -She did not know why her cheeseburger was cut up like that. -She had a problem swallowing; that was why staff gave her "thick drinks." Attempted telephone interview with Resident #4's power of attorney on 09/18/19 at 4:55pm was unsuccessful. Observation of the dinner meal service on 09/18/19 at 5:30pm revealed Resident #4 was served a pizza that was cut up and a chocolate popsicle. Observation of the cook on 09/18/19 at 12:57pm revealed he used a knife and cut a cheeseburger on a bun into eight pie shaped wedges while the cheeseburger was on the plate for a mechanical	{D 310}		

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{D 310}	Continued From page 40 soft diet. Observation of the dinner meal on 09/19/19 at 5:00pm revealed Resident #4 was served a cup of sherbet ice cream. Interview with the Kitchen Manager on 09/19/19 at 5:00pm revealed: -He did not know residents on a thickened liquid could not have ice cream or gelatin; he did not have a guide to follow for thicken liquids. -He would give Resident #4 pudding and remove the sherbet. Residents on a nectar thick liquid should avoid foods that melt in the mouth and turn into a thin liquid; including ice cream, sherbet, slushies, gelatins, and milkshakes. Refer to interview with the cook on 09/19/19 at 4:02pm. Refer to interview with the Kitchen Manager on 09/18/19 at 9:54am. Refer to interview with the Resident Care Director (RCD) on 09/19/19 at 2:31pm. The Administrator was not available for interviews. 3. Review of Resident #3's current FL-2 dated 01/31/19 revealed diagnoses included schizophrenia, personality disorder, bipolar mood disorder, diabetes mellitus, hypertension, hypothyroidism, gastroesophageal reflux disease, and irritable bowel syndrome. Review of Resident #3's primary care provider	{D 310}		

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{D 310}	Continued From page 41 (PCP) orders revealed: -There was an order dated 07/11/19 for a no added table salt (NATS), mechanical soft with chopped meats diet. -There was a hospital discharge summary dated 07/24/19 with instructions for a low sodium heart healthy diet and to follow a heart healthy and modified carbohydrates diet. -The discharge summary was signed and resident's PCP and dated 07/25/19. Interview with Resident #3's PCP on 09/19/19 at 10:05am revealed: -The facility did not offer a low sodium heart healthy diet. -There should have been an order in the record resuming the NATS, chopped meats diet. Review of the current diet order notebook on 09/19/19 at 10:04am revealed there was an order for Resident #3 dated 07/11/19 for a NATS, mechanical soft with chopped meats diet. Observation of the dinner meal on 09/17/19 revealed: -Resident #3 used salt to season her dinner. -There were opened salt packets to the right of her dinner plate. Observation of the lunch meal on 09/18/19 revealed Resident #3 was served a cheeseburger that was not chopped. Interview with Resident #3 on 09/19/19 at 9:08am revealed: - She did not know her diet order. -"I love salt. They don't want me to eat salt." -The dietary aides (DA) (names unknown) stopped giving her salt on 09/18/19.	{D 310}		

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{D 310}	Continued From page 42 Interview with Resident #3 on 09/19/19 at 10:40am revealed: -She knew she was ordered a chopped meats diet. -She did not tell the DAs to chop her cheeseburger at lunch on 09/18/19. -She ate her cheeseburger without it being chopped. -She did not remember who told her she could not have any salt with her meals. -She had salt earlier in the week but could not remember which day. Interview with the Resident Care Director (RCD) on 09/19/19 at 10:45am revealed: -His expectation was diet orders would be followed as written. -Resident #3 had swallowing issues in the past. -Managers on duty on weekends observed one meal service. -The protocol was to talk with kitchen staff if any matters of concern were observed. Interview with the cook and on 09/18/19 and 09/19/19 at 2:30pm and 4:02pm revealed: -He had worked in the kitchen for three years as a cook and had been trained how to prepare pureed and mechanical soft diets by another cook. -He had always cut hamburgers into pie shaped wedges for the mechanical soft diets and chopped meat diets; sometimes he would cut the hamburger into squares. -Mechanical soft and chopped meat diets should be cut smaller than finger foods and need a fork to eat. -He pureed food in the food processor and sometimes he would add water if it was too thick; he knew not to make the pureed food too runny or to leave chunks in the pureed food when done.	{D 310}		

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{D 310}	Continued From page 43 -Pureed food should look like pudding. Interview with the Kitchen Manager on 09/19/19 at 11:40am revealed: -He had been the Kitchen Manager for a month; he was a cook before he was the Kitchen Manager. -He was trained on how to prepare mechanical soft and pureed foods by the previous Kitchen Manager. -He prepared the mechanical soft for each plate as he platted the resident's food. -He pureed the food for the residents right before he served it. -Mechanical soft food was supposed to be bite sized and the pureed food was not supposed to be a smooth texture without being too runny. -Sometimes it was difficult to get pureed food to the right texture. Interview with the RCC on 09/19/19 at 2:31pm revealed: -He did meal observations in the dining room when he worked weekends. -He checked the consistency of the food with the diet order for the residents; the resident diet list was in the kitchen. -He would let the kitchen staff know if the food was not the correct consistency or texture. -He had only had a concern once, when a mechanical soft food item was only cut down the middle and not into smaller pieces and he had to send the plate back to the kitchen to correct. -Mechanical soft food was not ground but cut into little bite size pieces, and "real" soft. -Pureed foods were processed in a blender with a little water to a gelatin texture, not real "runny or watery". -He did not train the kitchen staff and he was not sure who trained the kitchen staff on how to	{D 310}		

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{D 310}	Continued From page 44 prepare the therapeutic diets. _____ The facility failed to serve two residents a mechanical soft diet, one resident nectar thick liquids as ordered for difficulties with swallowing, and another resident that was not served a pureed diet as ordered whiched placed the resident at risk for choking and vomiting during meals. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/19/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 3, 2019.	{D 310}		
{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 45 This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance to the facility's policy for 5 of 9 residents (#10, #6, #11, #9, #8) observed during the medication pass, including errors with a pancreatic enzyme replacement medication, insulin, an antiemetic, and an oral antidiabetic medication; and for 2 of 5 residents (#6, #4) sampled for record review including errors with a medication used to treat diabetes (#6), and eye drops and an antidepressant (#4). The findings are: 1. The medication error rate was 19% as evidenced by the observation of 5 errors out of 27 opportunities during the 4:30pm medication pass on 09/17/19. Review of the facility's medication administration policy dated on 09/01/10 revealed: -Staff should ensure .....the administration or observation of medication according to times of administration as determined by the facility. -Staff should assist with administration .... of medications ordered before meals approximately thirty minutes before meal times and should administer .....medications ordered to be given after meals no later than thirty minutes after a	{D 358}		

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{D 358}	Continued From page 46 meal has ended. a. Review of Resident #10's current FL-2 dated 01/17/19 revealed diagnoses included hypokalemia and alcohol abuse. Review of a physician orders for Resident #10 revealed an order dated 06/13/19 for Creon 12,000-38,000-60,000-unit delayed release capsules, take three capsules before meals. (Creon is used for pancreatic enzyme replacement to aid in the digestion of food in certain pancreatic conditions.) Review of an after-visit summary from Resident #10's gastroenterology Physician Assistant (PA) dated 02/22/18 revealed: -There was documentation which read Creon was to be taken right before all meals, not scheduled times per day. -Please take three capsules before all meals. Observation of the 4:30pm medication pass on 09/17/19 revealed: -The medication aide (MA) approached Resident #10, who was standing in the hallway. -She obtained three capsules of Creon from the blister pack, placed the capsules in a souffle cup and gave Resident #10 the cup and a small plastic cup of water. -The resident took the three capsules of Creon at 3:34pm. -The MA did not offer a snack to the resident. Interview with the MA on 09/17/19 at 3:35pm revealed: -She had a one-hour window to administer medications, meaning if the medication was scheduled at 4:30pm, she could administer the medication as early as 3:30pm.	{D 358}		

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{D 358}	Continued From page 47 -Resident #10 had snacks in his room to eat if he wanted, but he would be eating supper at 5:00pm anyway. -If the order was for the medication to be administered before meals, she tried to administer it before meals. Interview with Resident #10 on 09/17/19 at 4:00pm revealed: -He had his own snacks in his room, but he did not eat anything when the MA gave him his medications earlier. -He was not hungry and was going to wait until supper to eat. -He always took his medications when the MA told him it was time for them. -He thought he remembered "the doctor" saying he should take something with meals, but he did not know what medication it was. Observation of the dinner meal service on the assisted living on 09/17/19 from 4:55pm-5:32pm revealed: -Resident #10 was in the dining room with the other residents. -The first resident received their dinner plate at 5:27pm. Based on observation of the medication pass and the dinner meal service, Resident #10 was administered Creon at least 1 hour and 53 minutes before his dinner meal. Review of Resident #10's electronic medication administration record for September 2019 revealed: -There was an entry for Creon capsule, delayed release, 12,000-38,000-60,000 unit, take three capsules before meals, scheduled for 7:30am, 11:30am, and 4:30pm.	{D 358}		

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{D 358}	Continued From page 48 -There was documentation Creon was administered three times daily before meals from 09/01/19-09/17/19. Interview with another MA on 09/18/19 at 8:00am revealed: -If the medication order was written for any medication to be administered before meals, the MAs should administer the medication 30 minutes before the meal. -For example, if the medication was scheduled for 8:00am, the MAs should administer the medication no earlier than 7:30am. -The pharmacy staff entered times to administer medications on the e-MAR. -MAs could not change the times entered on the e-MAR; they would have to contact the pharmacy if there was an issue with the scheduled administration times. Interview with the Memory Care Manager (MCM) on 09/17/19 at 4:10pm revealed: -The MAs had one hour before and one after the scheduled times on the e-MAR to administer medications. -If a medication was ordered before or with meals, the MAs still had one hour before and one hour after the scheduled time indicated on the e-MAR to administer medications. Interview with the Resident Care Coordinator (RCC) on 09/17/19 at 4:30pm revealed if a medication was ordered with meals, the medication should be administered when the resident ate. Interview with the Resident Care Director (RCD) on 09/18/19 at 9:50am revealed: -The RCD, RCC or MCM checked behind every order the pharmacy staff entered into the e-MAR.	{D 358}		

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{D 358}	Continued From page 49 -The pharmacy staff entered times for medications to be administered, but he, the RCC or the MCM could change the times if needed. -The MAs did not have access to change scheduled times on the e-MAR. Interview with the corporate Executive Director (ED) on 09/17/19 at 4:45pm revealed: -If a medication was ordered with meals, the MA should administer the medication with the meal. -If the medication was ordered before meals, it was okay for the MAs to administer those medications 30 minutes before the meal. Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/18/19 at 12:14pm revealed: -Creon would not work if it was not administered with food because the pancreas could not break down the food without it. -According to the manufacturer, Creon should always be administered with a meal or snack. Interview with Resident #10's primary care provider (PCP) on 09/19/19 at 10:05 am revealed Resident #10's gastroenterologist needed to be contacted to discuss any concerns about Creon being administered before the resident ate. Telephone interview with the nurse for Resident #10's gastroenterologist on 09/19/19 at 2:40pm revealed: -It would be very concerning if Creon was not administered correctly. -Creon should always be given with the first bite of food, not even ten minutes before. -Resident #10 had a pancreatic cyst, so if Creon was not administered with food, it would impede the digestion of enzymes, including amylase, lipase and protease.	{D 358}		

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{D 358}	Continued From page 50 -The enzymes would not drain into the small intestines to break down the food Resident #10 ate. -The resident would not get the full nutritional benefit of the food. -Not administering Creon with food could result in the resident experiencing bloating, diarrhea, stomach cramping, and vitamin deficiencies. -All fat consumed by the resident would not digest properly. -Failure to receive Creaon with meals could cause also cause chronic diarrhea which could lead to malnutrition. Refer to interview with the Business Office Manager on 09/17/19 at 9:30am. b. Review of Resident #6's current FL-2 dated 03/13/19 revealed diagnoses included diabetes mellitus, developmental disorder, intellectual disability and hypertension. Review of a physician's order for Resident #6 revealed: -There was an order from the primary care physician (PCP) dated 03/12/19 to continue checking blood glucose four times/day (before meals and at bedtime). -There was an order from Resident #6's PCP dated 08/13/19 for Humalog sliding scale insulin (SSI) as follows: 200-250 = 8 units; 251-300 = 13 units; 301-350 = 18 units; 351-400 = 23 units; greater than 400, call doctor. (Humalog is a rapid acting insulin that starts to lower blood sugar within 15 minutes of administration.) Review of the Humalog manufacturer's safety instructions revealed Humalog was to be taken 15 minutes before eating or immediately after a meal.	{D 358}		

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{D 358}	Continued From page 51 Observation of the 4:30pm medication pass on 09/17/19 revealed: -The medication aide (MA) entered Resident #6's room and obtained Resident #6's blood glucose at 3:45pm; the blood glucose result was 221. -The MA prepared 8 units of Humalog insulin and administered Humalog subcutaneously in Resident #6's right arm at 3:49pm. Interview with the MA on 09/17/19 at 3:52pm revealed: -She usually administered insulin one hour before meals. -According to the facility's policy, the MAs had one hour before or one hour after the scheduled times on the electronic medication administration record (e-MAR) to administer medications, including insulin. -She gave fast acting insulin, including Humalog, one hour before meals. -Meals were served at 8:00am, 12:00pm and 5:00 pm. Interview with Resident #6 on 09/17/19 at 3:50pm -It would be "suppertime soon." -It had not "been too long" since he ate a snack. Observation of the dinner meal service on the assisted living on 09/17/19 from 4:55pm-5:32pm revealed Resident #6 took his first bite of food at 5:32pm. Based on observation of the 4:30pm medication pass and the dinner meal on 09/17/19, Resident #6 received Humalog insulin 1 hour and 43 minutes before receiving his dinner meal. Review of Resident #6's e-MAR for September 2019 revealed:	{D 358}		

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{D 358}	Continued From page 52 -There was an entry for "blood sugars" before meals and at bedtime, scheduled at 7:00am, 12:00pm, 5:00pm and 9:00pm. -There was an entry for Humalog insulin per sliding scale before meals as follows: 200-250 = 8 units; 251-300 = 13 units; 301-350 = 18 units; 351-400 = 23 units, greater than 400, call doctor. -Humalog was scheduled for 7:00am, 11:00am, and 4:00pm. -There was documentation Humalog was administered according to the sliding scale from 09/01/19-09/17/19. -Resident #6's blood glucose ranged from 127-500 from 09/01/19-09/17/19. Interview with another MA on 09/18/19 at 8:00am revealed: -If the medication order was written for any medication to be administered before meals, the MAs should administer the medication 30 minutes before the meal. -For example, if the medication was scheduled for 8:00am, the MAs should administer the medication no earlier than 7:30am. -The pharmacy staff entered times to administer medications on the e-MAR. -MAs could not change the times entered on the e-MAR; they would have to contact the pharmacy if there was an issue with the scheduled times. Interview with the Memory Care Manager (MCM) on 09/17/19 at 4:10pm revealed: -The MAs had one hour before and one after the scheduled times on the e-MAR to administer medications. -If a medication was ordered before or with meals, the MAs still had one hour before and one hour after the scheduled time indicated on the e-MAR to administer medications.	{D 358}		

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{D 358}	Continued From page 53 Interview with the Resident Care Coordinator (RCC) on 09/17/19 at 4:30pm revealed if a medication was ordered before meals, the earliest the MAs should administer insulin, or any diabetic medications was 30 minutes before the residents ate their meal. Interview with the corporate Executive Director (ED) on 09/17/19 at 4:45pm revealed: -If a medication was ordered with meals, the MA should administer the medication with the meal. -If the medication ordered before meals was a diabetic medication or insulin, it was okay for the MAs to administer those medications 30 minutes before the meal. -Any other medication was one hour before or one hour after the scheduled time indicated on the e-MAR. Interview with the Resident Care Director (RCD) on 09/18/19 at 9:50am revealed: -The MAs had the one-hour window to administer medications, but if the order was written to be administered with meals, the MAs needed to administer the medication 30 minutes before the meal "at most." -It was lack of education and training for the MAs. -The MAs were not licensed staff, so they did not always understand the significance of timing issues with medications and meals. -It would be "preferable" for the medication to be administered with a meal or snack if the medication was ordered with meals. Telephone interview with the nurse at Resident #6's endocrinologist's office on 09/19/19 at 8:00am revealed he should receive Humalog 30 minutes at maximum prior to eating; otherwise, his FSBS would drop.	{D 358}		

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{D 358}	Continued From page 54 Review of a fax sent to Resident #6's PCP on 09/18/19 revealed a request to give the resident a snack if the meal was not available within 30 minutes of Humalog administration; the request was signed by the PCP and dated 09/18/19. Refer to interview with the Business Office Manager on 09/17/19 at 9:30am. c. Review of Resident #11's current FL-2 dated 02/28/19 revealed diagnoses included diaphragmatic hernia, hyperlipidemia, hypertension and intellectual disability. Review of a physician's order for Resident #11 dated 06/13/19 revealed an order for metoclopramide HCL (metoclopramide is generic Reglan), take one tablet before meals. (Reglan is an antiemetic used to treat nausea and heartburn.) Review of the manufacturer's administration guidelines for Reglan revealed Reglan should be administered 30 minutes before each meal and at bedtime. Observation of the 4:30pm medication pass on 09/17/19 revealed: -The medication aide (MA) obtained one Reglan tablet from the blister pack, crushed the tablet and mixed it with less than one teaspoon of yogurt in a souffle cup. -The MA gave the crushed medication and yogurt to Resident #11 with a small cup of water at 3:52pm. Interview with the MA on 09/17/19 at 4:35pm revealed: -She always crushed Resident #11's medications. -The MAs had a one-hour window to administer	{D 358}		

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medications, meaning they had one hour before or one hour after the scheduled time on the electronic medication administration record (e-MAR) to administer medications.
-Dinner was served at 5:00pm, so she thought it would be okay to administer Resident #11's Reglan at 3:52pm.

Based on observations, interviews and record reviews, it was determined Resident #11 was not interviewable.

Observation of the dinner meal on the assisted living on 09/17/19 from 4:55pm-5:30pm revealed:
-Resident #11 was in the dining room with other residents
-The first resident received their dinner meal at 5:27pm.

Based on observation of the medication pass and the dinner meal, Resident #11 received Reglan at least 1 hour and 35 minutes before receiving her dinner meal.

Review of Resident #11's e-MAR for September 2019 revealed:
-There was an entry for Reglan 10mg, take one tablet before meals, scheduled for 7:00am, 11:00am and 4:00pm.
-There was documentation Reglan was administered at 7:00am, 11:00am and 4:00pm from 09/01/19-09/17/19.

Interview with another MA on 09/18/19 at 8:00am revealed if the medication order was written to be administered before meals, the MAs should administer the medication 30 minutes before the meal.

Interview with the Memory Care Manager (MCM)

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on 09/17/19 at 4:10pm revealed:
-The MAs had one hour before and one after the scheduled times on the e-MAR to administer medications.
-If a medication was ordered before meals, the MAs had one hour before and one hour after the scheduled time indicated on the e-MAR to administer medications.

Interview with the Resident Care Coordinator (RCC) on 09/17/19 at 4:30pm revealed if a medication was ordered before meals, the earliest the MAs should administer was 30 minutes before the residents ate their meal.

Telephone interview with the pharmacist from the facility's contracted pharmacy on 09/19/19 at 8:54am revealed:
-Reglan was used for different purposes.
-The main use was to give the feeling of a full stomach, another was to enhance gastric mobility, and a third was to prevent nausea and treat gastroesophageal reflux disease.
-A secondary use for Reglan was it helped with swallowing to prevent strangulation.
-The sensation of a full stomach could slow down the eating process also preventing strangulation.
-Reglan could take 30 to 60 minutes to take effect and it lasted one to two hours before it started to lose its effectiveness.

Interview with Resident #11's primary care provider (PCP) on 09/19/19 at 10:05am revealed Resident #11 needed to eat 30 minutes to one hour before she was administered Reglan.

Refer to interview with the Business Office Manager on 09/17/19 at 9:30am.

d. Review of Resident #9's current FL-2 dated

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{D 358}	Continued From page 57 03/29/19 revealed: -Diagnoses included dementia, diabetes, hypertension, and anemia. -There was a physician's order for metformin 1000mg, take one tablet twice daily. (Metformin is used to lower blood sugar levels). Review of subsequent physician's orders for Resident #9 revealed: -There was an order dated 03/06/19 to check Resident #9's FSBS twice a day, once in the early morning and once before dinner. -There was a prescription dated 05/29/19 for metformin 1000mg, take one tablet twice daily with a meal. Review of the manufacturer's administration guidelines for Metformin revealed Metformin should be administered with meals. Observation of the 4:30pm medication pass on the Special Care Unit (SCU) on 09/17/19 revealed: -Resident #9 was sitting in the sitting area on the SCU. -At 3:40pm, the medication aide (MA) obtained Resident #9's FSBS; the result was 246. -At 3:59pm, the MA obtained one metformin 1000mg tablet from a blister pack, placed the tablet in a souffle cup and administered the medication to Resident #9. Interview with the MA on 09/17/19 at 4:00pm revealed: -The MAs had one hour before and one after the scheduled times on the electronic medication administration record (e-MAR) to administer medications. -Resident #9's metformin was scheduled to be administered at 4:00pm; he would eat supper at	{D 358}		

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{D 358}	Continued From page 58 5:00pm. Observation of the dinner meal on the SCU on 09/17/19 from 5:00pm-5:30pm revealed Resident #9 took his first bite of the dinner meal at 5:32pm. Based on observation of the medication pass and the dinner meal on 09/17/19, Resident #9 received metformin 1 hour and 33 minutes before he was served his meal. Review of Resident #9's e-MAR for September 2019 revealed: -Resident #9's FSBS result for 09/17/19 at 4:00pm was documented as 165. -Resident #9's FSBS ranged from 137-263 in September 2019. -There was an entry for metformin 1000mg, take one table twice daily with a meal, scheduled for 7:00am and 5:00pm. -There was documentation metformin was administered twice daily from 09/01/19-09/17/19. Interview with the Memory Care Manager (MCM) on 09/17/19 at 4:10pm revealed: -The MAs had one hour before and one after the scheduled times on the e-MAR to administer medications. -If a medication was ordered with meals, the MAs had one hour before and one hour after the scheduled time indicated on the e-MAR to administer medications. Interview with the Resident Care Coordinator (RCC) on 09/17/19 at 4:30pm revealed if a medication was ordered with meals, the medication should be administered when the resident ate. Interview with the corporate Executive Director	{D 358}		

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{D 358}	Continued From page 59 (ED) on 09/17/19 at 4:45pm revealed if a medication was ordered with meals, the MA should administer the medication with the meal. Interview with the Resident Care Director (RCD) on 09/18/19 at 9:50am revealed the MAs had the one-hour window to administer medications, but if the order was written to be administered with meals, the MAs needed to administer the medication 30 minutes before the meal "at most." Telephone interview with the nurse for Resident #9's primary care provider on 09/19/19 at 8:45am revealed: -She was not as concerned about metformin being given so early related to his blood sugar dropping. -She was more concerned that no food was offered to him and the metformin could cause an upset stomach. -She sent a new order on 09/18/19 to make sure to offer a snack if the meal was not available when metformin was administered. -She was not told the resident was administered metformin 1 hour and 33 minutes before he ate on 09/17/19; staff at the facility told her it was administered 30 minutes before he ate his meal. Review of a prescription dated 09/18/19 revealed an order for metformin 1000mg, take one table two times daily with a snack if the meal was unavailable within 30 minutes. Based on observation, interview and record review, it was determined Resident #9 was not interviewable. Refer to interview with the Business Office Manager on 09/17/19 at 9:30am.	{D 358}		

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{D 358}	Continued From page 60 e. Review of Resident #8's current FL-2 dated 01/17/19 revealed: -Diagnoses included Alzheimer's disease, type 2 diabetes mellitus, hypertension, and major depressive disorder. -There was a physician's order for metformin 1000mg, take one tablet twice daily with meals. (Metformin is used to lower blood glucose levels). Review of a subsequent physician's order for Resident #8 dated 07/18/19 revealed an order for metformin 1000mg, take one tablet twice daily with meals. Review of the manufacturer's administration guidelines for Metformin revealed Metformin should be administered with meals. Observation of the 4:30pm medication pass on 09/17/19 revealed: -The medication aide (MA) obtained one tablet of metformin from a blister pack and placed in a souffle cup. -She administered the metformin to Resident #8 at 4:05pm. Interview with the MA on 09/17/19 at 4:00pm revealed: -The MAs had one hour before and one after the scheduled times on the electronic medication administration record (e-MAR) to administer medications. -Resident #8's metformin was scheduled to be administered at 4:00pm; he would eat supper at 5:00pm. Based on observation, interview and record review, it was determined Resident #8 was not interviewable.	{D 358}		

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{D 358}	Continued From page 61 Observation of the dinner meal on the SCU on 09/17/19 from 5:00pm-5:30pm revealed Resident #8 took her first bite of the dinner meal at 5:27pm. Based on observation of the medication pass and the dinner meal on 09/17/19, Resident #8 received metformin 1 hour and 22 minutes before she was served her meal. Review of Resident #8's e-MAR for September 2019 revealed: -There was an entry for metformin 1000mg, take one tablet twice daily with meals, scheduled for 8:00am and 5:00pm. -There was documentation metformin was administered twice daily from 09/01/19-09/17/19. Interview with the Memory Care Manager (MCM) on 09/17/19 at 4:10pm revealed if a medication was ordered with meals, the MAs had one hour before and one hour after the scheduled time indicated on the e-MAR to administer medications. Interview with the Resident Care Coordinator (RCC) on 09/17/19 at 4:30pm revealed if a medication was ordered with meals, the medication should be administered when the resident ate. Interview with the corporate Executive Director (ED) on 09/17/19 at 4:45pm revealed if a medication was ordered with meals, the MA should administer the medication with the meal. Interview with the Resident Care Director (RCD) on 09/18/19 at 9:50am revealed: -The MAs had the one-hour window to administer medications, but if the order was written to be	{D 358}		

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{D 358}	Continued From page 62 administered with meals, the MAs needed to administer the medication 30 minutes before the meal "at most." -It would be "preferable" for the medication to be administered with a meal or snack if the medication was ordered with meals. Interview with Resident #8's primary care provider (PCP) on 09/19/19 at 10:05 am revealed Resident #8's metformin should be administered within one hour of a meal. Review of a new verbal order for Resident #8 dated 09/18/19 revealed a request to stop the current metformin order and start metformin 1000mg twice daily; the order was not signed by the PCP. Refer to interview with the Business Office Manager on 09/17/19 at 9:30am. 2. Review of Resident #6's current FL-2 dated 03/13/19 revealed diagnoses included diabetes mellitus, developmental disorder and intellectual disability. a. Review of an after-visit summary from Resident #6's endocrinologist dated 04/23/19 revealed an order for Trulicity 1.5mg/0.5ml, inject 1.5 mg under the skin once a week. (Trulicity is used to treat type 2 diabetes.) Review of an after-visit summary from Resident #6's endocrinologist dated 05/14/19 revealed an order for Trulicity 0.75mg weekly. Review of an order dated 07/31/19 from Resident #6's primary care provider (PCP) revealed an order for Trulicity 0.75mg/0.5ml once weekly.	{D 358}		

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{D 358}	Continued From page 63 Review of a prescription from Resident #6's endocrinologist dated 09/03/19 revealed an order for Trulicity 1.5mg/0.5ml, inject 1.5mg under the skin once a week. Review of Resident #6's electronic medication administration records (e-MAR) for April 2019 revealed: -There was no entry or documentation of administration for Trulicity. -Resident #6's blood sugar was obtained four times daily and ranged from 93-400. Review of Resident #6's e-MAR for May 2019 revealed: -There was no entry or documentation of administration for Trulicity. -Resident #6's blood sugar was obtained four times daily and ranged from 147-411. Review of Resident #6's e-MAR for June 2019 revealed: -There was no entry or documentation of administration for Trulicity. -Resident #6's blood sugar was obtained four times daily and ranged from 137-400. Review of Resident #6's e-MAR for July 2019 revealed: -There was no entry or documentation of administration for Trulicity. -Resident #6's blood sugar was obtained four times daily and ranged from 119-382. Review of Resident #6's e-MAR for August 2019 revealed: -There was an entry for Trulicity 0.75mg/0.5ml, inject once weekly, with a start date of 08/07/19 and an end date of 09/03/19 by the entry. -Trulicity was documented as administered on	{D 358}		

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08/27/19, which was a Tuesday.
-There was no documentation Trulicity was administered any other dates in August 2019.
-Resident #6's blood sugar was obtained four times daily and ranged from 147-411.

Review of Resident #6's e-MAR for September 2019 revealed:
-There was an entry for Trulicity 0.75mg/0.5ml, inject once weekly, with a start date of 08/07/19 and an end date of 09/03/19 by the entry.
-Trulicity was documented as administered on 09/03/19.
-There was no documentation Trulicity was administered any other dates in September 2019.
-Resident #6's blood sugar was obtained four times daily from 09/01/19-09/17/19 and ranged from 121-500.

Observation of medications on hand for Resident #6 on 09/19/19 at 10:50am revealed there were two unopened Trulicity 1.5mg/0.5ml pens with a dispense date of 04/22/19.

Review of Resident #6's electronic progress notes revealed there was no documentation about Trulicity being unavailable to administer.

Telephone interview with a representative from the facility's contracted pharmacy on 09/19/19 at 8:30am revealed:
-There was an order for Resident #6 for Trulicity 1.5mg weekly received on 03/31/19.
-Two pens were last dispensed on 04/22/19, which was a two-week supply.
-Another order was received on 09/03/19 for Trulicity 0.75mg weekly, and Resident #6's insurance denied paying for the Trulicity when the pharmacy tried to dispense the medication to the facility. Prior to that date, his insurance had

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{D 358}	Continued From page 65 covered the injection. -The pharmacist notified the facility staff Resident #6's insurance rejected Trulicity via fax on 09/03/19. -Trulicity was not on cycle fill; staff would have to request it be refilled. -The pharmacy staff entered orders on the e-MAR. -Facility staff approved the orders entered on the e-MAR. -She did not know why the entry did not appear on the e-MAR for administration from April-July 2019; facility staff must have deleted the order from the e-MAR. -The pharmacy staff would not dispense a medication and then, discontinue the order from the e-MAR. -The order was discontinued from the September e-MAR once the insurance rejected the Trulicity; the pharamcy staff discontinued the order at that point because they were unable to dispense Trulicity until clarification was received from the provider by the facility staff. Interview with a medication aide (MA) on 09/19/19 at 10:50am revealed: -She did not know why the two pens of Trulicity for Resident #6, dispensed in April 2019, remained in the refrigerator. -She was not aware of an issue with his insurance rejecting the injection. -Trulicity was not "popping up" on the e-MAR for her to administer today, 09/19/19; she could not recall if Trulicity had ever been on the e-MAR for her to administer. -Trulicity was not on cycle fill and had to be reordered by the MAs. Interview with the Resident Care Director (RCD) on 09/18/19 at 9:50am revealed:	{D 358}		

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{D 358}	Continued From page 66 -He did not know what happened with Resident #6's Trulicity. -The RCD, residetn care coordinator (RCC) or memory care manager (MCM) checked behind every order the pharmacy staff entered the e-MAR. Second interview with the RCD on 09/19/19 at 11:10am revealed: -He was not aware of an issue with Resident #6's Trulicity, and did not know why Resident #6 was not administered Trulicity from April 2019-July 2019. -He was not aware of the insurance rejecting Trulicity in September 2019. -The order for Trulicity was showing discontinued in the computer system. -He, the RCC or MCM approved orders entered by the pharmacy staff. -The MAs could only fax orders to the pharmacy. -He did not know what happened with Resident #6's Trulicity, but he, the RCC or the MCM should check the orders received against what the pharmacy staff entered for accuracy. -They had to approve what the pharmacy staff entered for the entry to show up for the MAs to see. -If something was not entered by the pharmacy staff, it was the RCC, MCM or his responsibility to catch the error and enter the order. Third interview with the RCD on 09/19/19 at 2:30pm revealed: -The staff contacted Resident #6's PCP for everything, because it was "just easier" since the PCP was local. -Staff, including the RCC, RCD or MCM, "probably" did not look at the prescription every time and compare the order with what pharmacy staff entered onto the e-MAR.	{D 358}		

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{D 358}	Continued From page 67 -The RCD, RCC or MCM audited the medication carts every week which included comparing the medications in the cart with the orders entered on the e-MAR. Telephone interview with the nurse at Resident #6's endocrinologist's office on 09/19/19 at 8:00am revealed: -Resident #6's Trulicity was originally ordered for 0.75mg weekly, but it was increased to 1.5mg weekly on 09/03/19 because after looking at the hemoglobin A1C laboratory result for Resident #6, it appeared his diabetes was not managed, so the dose was increased. (Hemoglobin A1C measures a person's average blood sugar levels oever the past 3 months; the normal range for Hemogloblin A1C is below 5.7%). -The resident had not been getting the maximum dose when he was receiving 0.75mg. -Staff should be calling their office if there were missed doses of Trulicity. -The endocrinologist was not aware Resident #6 had not been receiving Trulicity as ordered. -Had the endocrinologist been aware Resident #6 did not receive Trulicity from April to July 2019, there was a possibility she would not have increased the Trulicity dosage; instead she increased the dosage for no reason. Attempted telephone interview with Resident #6's primary care provider on 09/19/19 at 12:30pm was unsuccessful. Refer to interview with the Business Office Manager on 09/17/19 at 9:30am. b. Review of 6 months physician's orders for Resident #6 dated 07/31/19 revealed an order to check FSBS before meals and at bedtime.	{D 358}		

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{D 358}	Continued From page 68 Review of an order from Resident #6's endocrinologist dated 08/07/19 revealed an order for Humalog, inject 15 units twice daily as needed for FSBS greater than 250. (Humalog is a fast-acting insulin used to lower blood glucose levels.) Review of Resident #6's August 2019 electronic medication administration records (e-MAR) revealed: -There was documentation Resident #6's FSBS was obtained four times daily before meals and at bedtime from 08/07/19-08/31/19. -There was documentation Resident #6's FSBS was greater than 250 for 51 opportunities from 08/07/19-08/31/19. -There was an entry for Humalog, inject 15 units twice daily as needed for FSBS greater than 250. -There was no documentation Humalog 15 units was administered for FSBS greater than 250. Review of an order from Resident #6's endocrinologist dated 09/03/19 revealed an order to discontinue Humalog 15 units twice daily as needed for FSBS greater than 250. Review of Resident #6's September 2019 e-MAR revealed: -There was documentation Resident #6's FSBS was obtained four times daily before meals and at bedtime from 09/01/19-09/03/19. -There was documentation Resident #6's FSBS was greater than 250 for 3 opportunities from 09/01/19-09/03/19. -There was an entry for Humalog, inject 15 units twice daily as needed for FSBS greater than 250; there was an end date of 09/03/19. -There was no documentation Humalog 15 units was administered for FSBS greater than 250 from 09/01/19-09/03/19.	{D 358}		

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{D 358}	Continued From page 69 Interview with a medication aide (MA) on 09/17/19 at 5:04pm revealed: -She was not aware of an order for Humalog 15 units twice daily as needed for FSBS greater than 250. -The MA had never seen this Humalog order "pop-up" on the e-MAR. Interview with another MA on 9/17/19 at 5:06pm revealed: -She did not work that medication cart often but had never seen this Humalog order on the e-MAR for Resident #6 if his blood sugar was greater than 250. -There should be documentation on the e-MAR by the prn entry if Humalog had been given for a FSBS over 250. Interview with the Resident Care Director (RCD) on 09/19/19 at 11:10am revealed: -He, the Resident Care Coordinator (RCC) or memory care manager (MCM) approved orders entered by the pharmacy staff. -There was an entry for Humalog 15 units if FSBS was greater than 250. -There had been so many changes in Resident #6's insulin, so the order was just missed. Telephone interview with the nurse at Resident #6's endocrinologist's office on 09/19/19 at 8:00am revealed: -There had been an as needed Humalog order for 15 units twice daily if FSBS was greater than 250, but the order was discontinued after the resident's last visit on 09/03/19. -Staff should have been giving the Humalog if there were FSBS greater than 250. -The endocrinologist expected for staff to follow orders as written for Resident #6, since he was	{D 358}		

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{D 358}	Continued From page 70 dependent on someone else to administer his medications -The resident would be at increased risk of uncontrolled diabetes, eleveated blood sugars, diabetic ketoacidosis (a serious complication of diabetes that occurs when the body produces high levels of blood acids called ketones and the body cannot produce enough insulin), and other organs could be affected if his diabetes was not under better control. Refer to interview with the Business Office Manager on 09/17/19 at 9:30am. 3. Review of Resident #4's current FL-2 dated 03/13/19 revealed diagnoses included glaucoma, hypertension, and depression. a. Interview with Resident #4 on 09/17/19 at 10:32 am revealed: -She had been getting an eye drop in her right eye to keep from losing her eye sight, but staff had stopped giving it to her. -She thought it had been a week since staff stopped giving her the eye drops; prior to a week ago, she had received the eye drops every night. -She had been getting eye drops in her right eye for a long time. -She had another eye drop, she thought, if she needed them for dry eyes. - "I am afraid to go blind." Review of primary care provider (PCP) orders for Resident #4 revealed: -There was an order dated 04/03/19 for Travatan 0.004% eye drops, instill one drop in both eyes at bedtime. (Travatan is used to treat glaucoma.) -There was a second order dated 07/08/19 for Travatan 0.004% eye drops, instill one drop in both eyes at bedtime.	{D 358}		

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{D 358}	Continued From page 71 -There was a prescription dated 08/06/19 for Travatan 0.004% eye drops, one drop into right eye in the evening for a 30-day supply and 3 refills. Review of the July 2019 electronic medication administration records (e-MAR) for Resident #4 revealed: -There was an entry for Travatan 0.004%, instill one drop in both eyes at bedtime, scheduled for 9:00pm. -There was documentation Travatan was administered at 9:00pm from 07/01/19-07/14/19 and from 07/17/19-07/31/19. -Travatan was documented as not administered on 07/15/19-07/16/19 due to the medication being unavailable. Review of the September 2019 e-MAR for Resident #4 revealed: -There was an entry for Travatan 0.004%, instill one drop into the right eye in the evening once a day for 30 days, scheduled at 9:00pm; there was a start date of 08/20/19 and an end date of 09/06/19. -Travatan was documented as administered from 09/01/09-09/06/19. -There was no documentation Travatan was administered from 09/07/19-09/18/19 and no reason documented for not adminsitering. Observation of Resident #4's medications on hand on 09/18/19 at 9:00am revealed there was no Travatan available for administration. Interview with the medication aide (MA) on 09/18/19 at 9:11am revealed: -She was assigned to administer medications to Resident #4. -There was no Travatan available to be	{D 358}		

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{D 358}	Continued From page 72	{D 358}		

administered to Resident #4.
-Travatan was not currently listed on the resident's e-MAR.

Interview with the same MA on 09/18/19 at 12:48pm revealed:
-She found a bottle of Travatan for Resident #4 on the medication cart.
-She was not sure why there were no eye drops entered on the e-MAR.
-The eye drops were administered at night so she could not say why they were not administered.
-She did not know if there was a discontinue order, but there was a stop date in the e-MAR, which meant the order would not "pop-up" for the MAs to administer.

Observation of the bottle of Travatan found by the MA on 09/18/19 at 12:48pm revealed:
-There was a 2.5 milliliter (ml) bottle of Travatan that was dispensed on 09/03/19.
-The bottle was approximately ¾ full.

Interview with another MA on 09/19/19 at 10:50am revealed:
-She worked the medication cart and was assigned to administer medications to Resident #4 one to two weeks ago.
-She did not give her any eye drops at that time because the eye drops had been discontinued from the e-MAR.
-The eye drops were not showing up to be administered.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/18/19 at 12:14pm revealed:
-Travatan was currently an active order for Resident #4.
-One bottle of Travatan eye drops was last

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dispensed on 09/03/19.
-If given as ordered, the bottle (dispensed on 09/03/19) would last 50 days.
-Travatan eye drops were used to treat glaucoma and should be given as ordered to prevent any recurrent symptoms or increased pressure in the eye.
-Travatan was not on cycle fill; staff had to reorder or request a refill.

Second telephone interview with a representative from the facility's contracted pharmacy on 09/19/19 at 11:49am revealed:
-The dispense date for Resident #4's Travatan prior to 09/03/19 was 07/15/19 for a 50-day supply.
-Facility staff had to approve orders entered by pharmacy staff.
-If something was missed, it was the facility staff's responsibility to enter the order or call the pharmacy for assistance.
-The only way there should be a stop or discontinue date for a medication on the e-MAR was if there was a discontinue order or change in a previous order.
-She did not know why there would be a stop date for Travatan since it was still an active order; there had been no discontinue orders received in the pharmacy.

Interview with the business office manager on 09/18/19 at 12:40pm revealed the MAs ordered refills when 5 days of doses remained to allow time for the physician to be contacted if there were no refills remaining.

Interview with the Resident Care Director (RCD) on 09/19/19 at 11:10am revealed:
-He, the resident care coordinator (RCC), or the memory care manager (MCM) approved orders

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entered by the pharmacy staff.
-The MAs could only fax orders to the pharmacy.
-Either he, the RCC or the MCM should have checked the orders received against what the pharmacy staff entered for accuracy.
-They had to approve what the pharmacy staff entered for the entry to show up for the MAs to see in the e-MAR system.
-If something was not entered by the pharmacy staff, it was his, the RCC, or the MCM's responsibility to catch the error and enter the order.
-He did not know why the Travatan had a discontinue date; he could not answer why the Travatan was not currently showing on the e-MAR.

Second interview with the RCD on 09/19/19 at 2:30pm revealed:
-Staff, including the RCD, RCC or MCM, probably did not look at the prescription every time and compare the order with what pharmacy staff entered onto the e-MAR.
-The RCD, RCC or MCM audited the medication carts every week, including checking the medications on the cart with the orders entered on the e-MAR.

Attempted telephone interview with the optometrist for Resident #4 on 09/19/19 at 3:41pm was unsuccessful.

Attempted telephone interview with Resident #4's primary care provider on 09/19/19 at 12:30pm was unsuccessful.

Refer to interview with the Business Office Manager on 09/17/19 at 9:30am.

b. Review of subsequent physician orders for

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{D 358}	Continued From page 75 Resident #4 revealed: -There was an order dated 04/03/19 for Venlafaxine (Venlafaxine is generic Effexor) extended release 75mg every day. (Effexor is used to treat depression.) -There was a second order dated 07/08/19 for Effexor 75mg with food once daily for 30 days with 11 refills. Review of the manufacturer's administration guidelines for Effexor revealed Effexor to be tapered as rapid discontinuation can be associated with agitation, confusion impaired coordination and balance. Review of Resident #4's electronic medication administration records (e-MAR) for August 2019 revealed: -There was an entry for Effexor 75mg, take one tablet with food once a day for 30 days, scheduled for 8:00am; there was a start date of 07/04/19 and an end date of 08/02/19. -There was documentation Effexor was administered from 08/01/19-08/02/19. -Effexor was documented as not administered for 29 of 31 opportunities in August 2019, with no explanation documented. Review of the September e-MAR for Resident #4 revealed there was no entry or documentation of administrationfor Effexor. Review of Resident #4's physician orders revealed there were orders to discontinue Effexor. Interview with the Memory Care Manager (MCM) on 09/18/19 at 9:18am revealed: -The Mental Health Provider (MHP) was at the facility every two weeks.	{D 358}		

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{D 358}	Continued From page 76 -The prescription the MHP wrote on 07/08/19 for Resident #4's Effexor was for 30 days. -She was not sure why the prescription would have 11 refills if it was only ordered for 30 days. -The MHP sent the prescription electronically to the pharmacy. Observation of Resident #4's medications on hand on 09/18/19 at 9:00am revealed there was no Effexor available for administration. Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/18/19 at 12:14pm revealed: -Effexor was an active order for Resident #4 from 07/03/19 for 75mg daily. -The pharmacy last dispensed Effexor for Resident #4 on 08/04/19 for a thirty-day supply. -Effexor was not on cycle fill; staff had to request the refill. -Facility staff had not requested a refill. -There were eleven refills on the original order dated 07/08/19, and nine refills remained. -The staff should not have stopped giving Effexor to Resident #4; stopping this medication abruptly could result in withdrawal symptoms, including increased depression, nausea and vomiting. Second telephone interview with a representative from the facility's contracted pharmacy on 09/19/19 at 11:49am revealed: -Thirty tablets of Effexor were dispensed on 07/09/19 and 08/04/19. -Facility staff had to approve orders entered by pharmacy staff and if something was missed, it was the facility staff's responsibility to enter the order or call the pharmacy for assistance. -The only way there should be a stop or discontinue date for a medication on the e-MAR was if there was a discontinue order or change in	{D 358}		

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{D 358}	Continued From page 77 a previous order. Interview with Resident #4 on 09/17/19 at 10:32 am revealed: -She thought she was receiving all her medications like she was supposed to, except her eye drops. -She had been feeling fine recently and had no complaints of dizziness or impaired coordination. -She used her walker to walk around her room and to the dining room, and had not had any recent falls. Interview with the Resident Care Director (RCD) on 09/19/19 at 11:10am revealed: -He, the resident care coordinator (RCC), or the memory care manager (MCM) approved orders entered by the pharmacy staff. -Either he, the RCC or the MCM should have checked the orders received against what the pharmacy staff entered for accuracy. -They had to approve what the pharmacy staff entered for the entry to show up for the MAs to see in the e-MAR system. -If something was not entered by the pharmacy staff, it was his, the RCC, or the MCM's responsibility to catch the error and enter the order. -He did not know why the Effexor was not administered in August nor why the entry for Effexor was not entered on the e-MAR for September; he could not provide any reason for the missed doses of Effexor. Second interview with the RCD on 09/19/19 at 2:30pm revealed: -Staff, including the RCD, RCC or MCM, probably did not look at the prescription every time and compare the order with what pharmacy staff entered onto the e-MAR.	{D 358}		

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{D 358}	Continued From page 78 -The RCD, RCC or MCM audited the medication carts every week, including observing what medications were available to be administered and comparing to orders entered on the e-MAR. -The order for Effexor should have been clarified from the MHP, because there was a discontinue date by the entry on the e-MAR, but no written discontinue order. -It was confusing how the MHP wrote orders, and it could be difficult contacting the MHP. -The MHP was at the facility every two weeks, and the provider received a printed copy of the current e-MAR; it looked like the MHP would have "caught" that the Effexor had not been administered as ordered. Attempted telephone interview with the MHP for Resident #4 on 09/19/19 at 8:28am was unsuccessful. Refer to interview with the Business Office Manager on 09/17/19 at 9:30am. _____ Interview with the Business Office Manager upon entrance to the facility on 09/17/19 at 9:30am revealed: -She would be the contact person. -The Executive Director for the facility would not be available for interview. _____ The facility failed to assure medications were administered as ordered and in accordance with the facility's policy for five residents observed during the medication pass as evidenced by a 19% error rate, including errors with administering medications before and with meals. Resident #6, who had a history of diabetes, was not administered Trulicity (used to treat diabetes) weekly from April 2019-July 2019; Trulicity was only administered twice in two months, resulting	{D 358}		

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{D 358}	Continued From page 79 in Resident #6's blood glucose results being elevated and the endocrinologist increasing the dose of Trulicity based on the elevated blood glucose results. This failure was detrimental to the health, safety and welfare of the residents, which constitutes a Type Unabated B Violation. _____ The facility provided a Plan of Protection for this violation in accordance with G.S. 131D-34 on 09/18/19.	{D 358}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to to assure every resident had received care and services which were adequate, appropriate, and in compliance with relevant state rules and regulations for personal care and supervision, medication admnistration and nutrition and food service. The findings are: 1 .Based on observations, record reviews and interviews, the facility failed to provide personal care assistance for nailcare for 2 of 7 sampled	{D912}		

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CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

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{D912}	Continued From page 80 residents (#1, #7). [Refer to Tag D 0269 10A NCAC 13F .0901(a) Personal Care and Supervision (Unabated Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance to the facility's policy for 5 of 9 residents (#10, #6, #11, #9, #8) observed during the medication pass, including errors with a pancreatic enzyme replacement medication, insulin, an antiemetic, and an oral antidiabetic medication; and for 2 of 5 residents (#6, #4) sampled for record review including errors with a medication used to treat diabetes (#6), and eye drops and an antidepressant (#4). [Refer to Tag D 0358 10A NCAC 13F .1004(a) Medication Administration (Type Unabated B Violation)]. 3. Based on observations, record reviews and interviews, the facility failed to assure therapeutic diets were served as ordered for 2 of 7 sampled residents with diet orders for a mechanical soft (MS) diet (Resident #3) and pureed diet (Resident #7). [Refer to Tag D0310 10A NCAC 13F. 0904(e)(4) Nutrition and Food Service (Type B Violation)].	{D912}		