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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE NORTH RALEIGH	5219 OLD WAKE FOREST RD RALEIGH, NC 27609

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D 000	Initial Comments The Adult Care Licensure Section and the Wake County Department of Social Services conducted an annual and follow-up survey on 07/26/22 - 07/28/22.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews the facility failed to provide supervision for 1 of 1 sampled resident (#2) who was known to be forgetful and required extensive staff assistance and had a history of falls resulting in multiple falls and closed head injury with extensive facial bruising and skin tears on both arms. The findings are: Review of the facility's Resident Falls Management policy dated January 2019 revealed: -Identify possible causes. -Develop an appropriate plan to minimize recurrence. -Ongoing monitoring and assistance for addressing the potential for falls. -Respond appropriately to incidents when they	D 270		

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occur.
-Evaluate and modify plans to prevent recurrence.
-Depending on the circumstances and interventions taken, this information should be reflected in the resident's Service/Care Plan, Resident Service Notes, Negotiated Risk Agreement, Incident Report, Nursing Assessing, Short-term Monitor and/or other records from outside health professionals, as indicated.

Review of Resident #2's current FL-2 dated 03/24/22 revealed:
-The resident's current level of care was Assisted Living Facility.
-Diagnoses included insomnia, depression hypertension, atrial fibrillation, pulmonary hypertension, chronic pain, cerebral infarction, and chronic left systolic and diastolic heart failure.
-The resident was intermittently disoriented and semi-ambulatory.
-The resident required personal care assistance with bathing, feeding, and dressing.

Review of Resident #2's Care Plan dated 09/03/21 revealed:
-The resident required extensive assistance with toileting, ambulation, bathing, dressing, and transferring.
-The resident required supervision while eating.
-The resident had limited range of motion and limited strength in both upper extremities and limited eye-hand coordination.
-The resident was sometimes disoriented, forgetful and needed reminders.
-There was no documentation of supervision requirements.

Review of Resident #2's physician's order Request/Clarification form dated 03/02/22 at

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D 270	Continued From page 2 7:00pm revealed: -The resident had a fall and injured her right side. -A verbal order for a 2-view chest x-ray. Review of Resident #2's Radiology Report dated 03/04/22 revealed osseous structures (tissue that gives strength and structure to bones) were stable. Review of Resident #2's fall assessment results completed on 04/21/22 revealed: -The resident had a history of falling. -The resident forgot gait limitations. -Resident #2 required implementation of standard fall prevention interventions. Review of Resident #2's Accident/Incident Report dated 04/26/22 at 9:45pm revealed: -Resident #2 paged staff and they found her sitting on the floor against her bed. -The resident stated she slipped from her wheelchair. -The resident was oriented. -The fall was unwitnessed. -A body check was completed on the resident and there were no injuries documented. -The resident refused to go to the hospital. Review of Resident #2's Accident/Incident Report dated 05/26/22 at 3:40pm revealed: -The resident had an unwitnessed fall and was found on the floor on her back (location not specified). -The resident was oriented. -A body check was completed and there were no injuries documented. -Emergency Medical Services (EMS) was called; however, the resident and the Power of Attorney (POA) did not want her to go to the Emergency Department (ED).	D 270		

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D 270	Continued From page 3 Review of Resident #2's Accident/Incident Report dated 05/29/22 at 11:15pm revealed: -The resident was found seated on the floor (location not specified). -The resident had an unwitnessed fall. -The resident was oriented. -A body check was completed, and the resident had no injuries documented. -The resident was assisted back into her wheelchair. -She was not sent out to the ED, because the resident and the POA did not want her to go to the ED. Review of Resident #2's Accident/Incident Report dated 06/04/22 at 4:00am revealed: -Resident #2 paged the staff and she was found on the floor in her room. -She slid on the floor while trying to transfer from the bed to her wheelchair. -The resident noted her legs gave out on her and she fell. -The resident was oriented. -A body check was completed on the resident, and she said she had pain in both of her legs. -Documentation noted the resident was seen by a nurse in the facility; however, no time or date was on the form. Review of Resident #2's Progress Notes on 06/04/22 at 3:00pm revealed, the resident had pain in her knee and was given a PRN tramadol. Review of Resident #2's Accident/Incident Report dated 06/05/22 at 10:30pm revealed: -Resident #2 was found lying on the floor near her bed on her left side. -A body check was completed on the resident, and she was assisted back in the bed.	D 270		

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-There was no documentation of injuries.
-A hospice nurse would be sent to the facility to assess the resident.

Observation of Resident #2 on 07/26/22 at 8:30am revealed:
-The resident was ambulating independently in her wheelchair on "A" hallway, after breakfast.
-The resident had a large reddish knot (gum ball size) with two dark spots above her right eye that extended to her hair line.
-There was yellowish coloring midline to her face that extended to hairline, right ear, jaw to lip line, bridge of nose, under the left eye and neck.
-There was red and dark purplish coloring under the right eye to the bottom of her jawbone and neck.

Interview with Resident #2 on 07/26/22 at 8:30am revealed:
-Her speech was low and slurred.
-The resident had been at the facility for two years.
-The resident fell in her room last week.

Review of Resident #2's Accident/Incident Report dated 07/20/22 at 11:12pm revealed:
-The resident was found on the floor in her room.
-The resident had a knot and bruising on her forehead.
-The resident told staff she was trying to put on her socks and fell out of the wheelchair.
-EMS was called and the resident was sent to the ED.
-The resident returned to the community with no new orders and the facility would follow-up with Resident #2's Primary Care Provider (PCP).

Review of Resident #2's EMS Report dated 07/20/22 revealed:

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-EMS was contacted at 11:15pm and dispatched at 11:17pm.
-Upon arrival the resident was found on her right side in front of the bathroom door.
-The resident had a golf ball size hematoma (a broken blood vessel that was damaged by surgery or an injury) above her right eyebrow.
-The resident's face had a lesion, swelling and tenderness.
-There was a bruise with swelling on her right wrist.

Review of Resident #2's ED Discharge Summary dated 07/21/22 at 1:25am revealed:
-The reason for resident's visit was a fall.
-Discharge diagnoses included fall, closed head injury and hematoma of scalp.

Interview with a personal care aide (PCA) on 07/27/22 at 6:58am revealed:
-Resident #2 required assistance with bathing, dressing, toileting, and grooming.
-The resident was able to propel herself in her wheelchair.
-Resident #2 was very independent and tried to do everything herself and would not use the call pendant to ask for assistance from staff, until after she fell.
-Resident #2 was a high fall risk and had multiple falls within the past few months.
-Resident #2 had a fall on 07/20/22 a little after 11:00pm.
-She saw Resident #2 on the floor and there was a knot on her forehead, so she went to get the Supervisor.
-The Supervisor checked Resident #2 and contacted EMS and she was transported to the ED.
-Resident #2 returned to the facility on 07/21/22.
-Staff conducted two-hour checks on all the

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residents in the Assisted Living Unit (AL).
-Resident #2 remained on two-hour checks, after each fall and no other interventions were implemented for her.

Telephone interview with a Supervisor on 07/26/22 at 4:00pm revealed:
-Resident #2 was independent and tried to do things herself.
-Resident #2 required assistance with toileting, dressing, bathing, and grooming.
-Resident #2 was independent with ambulating in her wheelchair.
-The PCA found Resident #2 on the floor near her bathroom on 07/20/22, at the start of third shift and notified her.
-The resident told her she fell out of the wheelchair, while trying to put on her socks.
-She observed a knot on Resident #2's forehead and checked the rest of her body.
-Resident #2 stated her head was hurting.
-She contacted EMS and they transported the resident to the ED.
-All AL residents were checked every two hours by staff.
-When she was hired in 03/2022, the Resident Services Coordinator (RSC) told her Resident #2 was a fall risk, and to make sure the resident wore her necklace call pendant, place the wheelchair near her bed and check on her every two hours.
-Upon Resident #2's return to the facility on the morning of 07/21/22, she independently started checking on the resident hourly.
-There were no new fall preventive interventions implemented for Resident #2 after any of her falls this year.

Telephone interview with Resident #2's POA on 07/27/22 at 10:47am revealed:

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-Resident #2 fell on 07/20/22, she was going "downhill."
-Resident #2 injured her head on 07/20/22 when she leaned down from her wheelchair to get something off the floor.
-Resident #2 scraped her hand on 07/26/22, while trying to get out of bed.
-The RSC told her they were checking on Resident #2 every two hours.

Review of Resident #2's Hospice Services notes dated 07/21/22 at 3:10pm revealed:
-The resident was lying in bed awake during the nursing visit.
-The resident had bruising to her right eye, forehead, nose as well as a lump on the right side of her forehead and a skin tear to her left forearm, due to a fall earlier this morning.
-The resident denied any pain and had no signs of pain.

Review of Resident #2's Accident/Incident Report dated 07/26/22 at 8:30pm revealed:
-The resident was found on the floor lying on her right side by her bed.
-The resident had a skin tear on her right arm.
-The resident told staff she was trying to get out of bed.
-The resident was not sent out to the hospital.
-The resident was scheduled to be seen by her PCP on 07/27/22.

Observation of Resident #2 on 07/27/22 at 10:40am revealed:
-The resident was asleep in bed.
-The resident had two skin tears on the inside of her left forearm and there was red bruising around the skin tears.
-One skin tear was the size of a nickel and the other the size of a dime.

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D 270	Continued From page 8 Interview with the RSC on 07/26/22 at 3:52pm revealed: -Resident #2 was a high fall risk. -Resident #2 was independent and tried to do things on her own. -The Supervisor telephoned her on 07/20/22 after 11:00 pm and reported Resident #2 fell on the floor and had a knot on her forehead. -EMS was contacted for Resident #2 and she was transported to the ED. -Prior to Resident #2 returning to the facility on 07/21/22, she told the Supervisor to check on Resident #2 more frequently than every two hours. -She had not wanted to specify a time frequency for checks on Resident #2, because she had not wanted to say something, they "had no documentation on." -After Resident #2 fell on 07/20/22, she spoke with the resident's POA about hiring a sitter for Resident #2. -She and the Resident Services Director (RSD) were responsible for completing resident fall assessments. -The RSD position had been vacant until 07/18/22. -No new fall prevention interventions had been created for Resident #2. Interview with the RSD on 07/27/22 at 8:12am revealed: -She started her position on 07/18/22. -She oversaw all resident care in the facility. -The Administrator was responsible for the RSD's tasks, during the position's vacancy. -At the moment, she did not know what Resident #2's fall prevention interventions were at the facility.	D 270		

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Interview with Resident #2's PCP on 07/27/22 at 9:23am revealed:
-Resident #2 was very independent.
-Resident #2 suffered from some dementia and liked to do things on her own and did not prefer asking for assistance.
-The PCP ordered Physical Therapy (PT) for Resident #2 on 07/13/22 and she had not followed up on her request.

Telephone interview with the hospice Director of Operations on 07/27/22 at 12:19pm revealed:
-Resident #2 became a patient at their agency in August 2021.
-After Resident #2's injurious fall on 07/20/22, their Hospice Liaison asked the facility about an alarm clip, so that each time the resident got up from her wheelchair or bed the alarm would sound.
-The hospice Liaison could not recall which staff person told her alarm clips were not allowed in the facility.
-Hospice wanted Resident #2 evaluated for PT for safety.

Interview with the Administrator on 07/27/22 at 8:54am revealed:
-Resident #2 was very independent, alert, oriented, liked to do things for herself, was receiving hospice services and had poor safety awareness.
-Resident #2 was checked many times per day with no set time for checks.
-The Administrator was unfamiliar with the facility's Resident Falls Management policy.

_____

The facility failed to provide supervision for Resident #2 who had a history of falls and was a high fall risk, resulting in the resident falling 7

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D 270	Continued From page 10 times between 04/26/22 and 07/26/22 and sustaining multiple bruises to her face, skin tears and bruising to both arms and a closed head injury. This failure resulted in serious physical harm and constitutes a Type A2 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/27/22 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 27, 2022.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 1 of 5 sampled residents (#4) related to not notifying the primary care provider (PCP) of elevated blood sugars. The findings are: Review of Resident #4's current FL-2 dated 06/27/22 revealed: -Diagnoses included Alzheimer's dementia and type 2 diabetes mellitus. -There was an order to check and record blood sugar twice a day, notify primary care provider (PCP) if blood sugar was less than 70 or greater	D 273		

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D 273	Continued From page 11 than 150. Review of Resident #4's May 2022 electronic medication administration record (eMAR) revealed: -There was an entry to check and record blood sugar twice a day, notify PCP if blood sugar was less than 70 or greater than 150. -The resident's blood sugar was scheduled to be checked at 7:30am and 4:30pm. -The resident's blood sugar was documented as greater than 150 on 18 occasions ranging from 152 - 183 on those 18 occasions. -There was no documentation the resident's PCP was notified of any of the 18 blood sugar readings greater than 150 as ordered. Review of Resident #4's June 2022 eMAR revealed: -There was an entry to check and record blood sugar twice a day, notify PCP if blood sugar was less than 70 or greater than 150. -The resident's blood sugar was scheduled to be checked at 7:30am and 4:30pm. -The resident's blood sugar was documented as greater than 150 on 18 occasions ranging from 151 - 241 on those 18 occasions. -There was no documentation the resident's PCP was notified of any of the 18 blood sugar readings greater than 150 as ordered. Review of Resident #4's July 2022 eMAR revealed: -There was an entry to check and record blood sugar twice a day, notify PCP if blood sugar was less than 70 or greater than 150. -The resident's blood sugar was scheduled to be checked at 7:30am and 4:30pm. -The resident's blood sugar was documented as greater than 150 on 16 occasions ranging from	D 273		

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151 - 190 on those 16 occasions.
-There was no documentation the resident's PCP was notified of any of the 16 blood sugar readings greater than 150 as ordered.

Review of Resident #4's facility progress notes and PCP notification forms revealed no documentation the PCP was notified for 52 of 52 blood sugar readings greater than 150 from 05/01/22 - 07/26/22.

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

Interview with a medication aide (MA) on 07/26/22 at 4:13pm revealed:
-If she had contacted Resident #4's PCP when the resident's blood sugar was greater than 150, it would be noted in the eMAR system or the electronic progress notes.
-She did not notify the PCP of a blood sugar reading greater than 150 on one occasion because she thought the resident's blood sugar was elevated because the resident ate lunch late.
-She did not remember if she had notified the PCP of any other elevated blood sugars for Resident #4.

Interview with a second MA on 07/27/22 at 10:10am revealed:
-The MAs could call or fax the PCP for any blood sugar readings outside of the ordered parameters.
-Resident #4's blood sugar was normally less than 120 and the highest she could remember was about 220.
-She was not sure about the parameters without looking at the eMAR.
-After reviewing the eMAR, she did not realize the

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ordered parameter was to contact the PCP when the blood sugar was greater than 150.
-She never contacted the PCP because she thought the parameter was to contact the PCP if the resident's blood sugar was greater than 500.

Interview with the Administrator on 07/26/22 at 4:28pm revealed:
-There was no documentation that Resident #4's PCP had been notified of blood sugar readings greater than 150.
-The Special Care Unit Coordinator (SCUC) just faxed Resident #4's blood sugar readings for the last 6 months to the PCP this afternoon (07/26/22).

Interview with the SCUC on 07/27/22 at 10:30am revealed:
-She was not aware the ordered parameter was to contact the PCP for blood sugar readings greater than 150.
-The MAs should be reviewing the eMARs for all orders including blood sugar parameters.
-The MAs should notify the PCP of blood sugar readings outside of the ordered parameters.
-If the MAs were busy, they could get her or the Resident Care Coordinator (RCC) to contact the PCP.
-She faxed the last 6 months of Resident #4's blood sugar readings to the PCP on 07/26/22.

Interview with the Resident Services Director (RSD) on 07/28/22 at 9:10am revealed:
-She just started working at the facility about 7 days ago so she was not aware of Resident #4's order to notify the PCP of blood sugars greater than 150.
-The MAs were responsible for notifying the PCP of blood sugars greater than 150 as ordered.
-The MAs should notify the PCP at the time the

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D 273	Continued From page 14 blood sugar was checked and noted to be greater than 150. Telephone interview with a registered nurse (RN) at Resident #4's PCP office on 07/28/22 at 9:50am revealed: -The PCP's office had not been contacted by the facility regarding elevated blood sugars for Resident #4. -The PCP's office should have been notified when the resident's blood sugar was greater than 150 because the resident could have experienced symptoms that warranted going to an urgent care provider or the emergency room. -It was possible the PCP would have made medication changes, depending on symptoms, if the elevated blood sugars had been reported to the PCP when they occurred.	D 273		
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 ensure therapeutic diet menus were available for 1 of 2 sampled residents (#4) with an order for a low sugar, diabetic, and low sodium diet.	D 296		

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D 296	Continued From page 15 The findings are: Review of Resident #4's current FL-2 dated 06/27/22 revealed: -Diagnoses included Alzheimer's disease, Type 2 diabetes mellitus and hypothyroidism. -The diet order documented "see diet order". Review of Resident #4's current diet order dated 06/27/22 revealed the resident required "Other prescribed diet" and on the line next to it documented a hand-written entry for "low sugar, diabetic, and low sodium diet". Observation of the kitchen on 07/27/22 at 7:00am revealed: -There was a daily menu for Wednesday posted in the kitchen; the menu was not dated. -The breakfast menu for Wednesday, week one was oatmeal (or cold cereal), scrambled egg, bacon, fresh fruit and 100% juice. -There were no other menus available for staff to reference in the kitchen. -There were no therapeutic menus and no week at a glance menu available for staff to follow. Review of a week at a glance menu provided by the Dietary Manager (DM) on 07/27/22 at 7:02am revealed: -The week at a glance was week one on a cycle menu. -The breakfast menu for Wednesday, week one was oatmeal (or cold cereal), scrambled egg, bacon, fresh fruit and 100% juice. Review of Resident #4's Dietary Communication Notification sheet provided by the DM on 07/27/22 at 7:04am revealed: -The dietary sheet was in a binder on a shelf at the DM desk in the kitchen.	D 296		

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-The dietary sheet was dated 05/05/21.
-The dietary sheet documented Resident #4 required a NCS (controlled carbohydrate) diet and that she was a diabetic.

Review of the diet extensions provided by the DM on 07/27/22 at 7:02am revealed:
-The therapeutic menu was week one of a cycle menu.
-The therapeutic diet extensions included diabetic-consistent carbohydrate (DB-CCHO) diet, mechanical soft chopped, mechanical soft ground, puree, and no added salt.
-There were no diet extension menus that included "Other prescribed diet" for "low sugar, diabetic, and low sodium diet".

Interview with the DM on 07/27/22 at 7:29am revealed:
-He had started working at the facility 3-4 months ago; he was new to the facility.
-He worked 7 days a week and had been hiring more dietary staff.
-He had worked on getting the kitchen cleaned and organized, including the menus.
-He was not was aware that the diet sheet he had for Resident #4 was over a year old.
-He was not aware the therapeutic diet forms, the facility provided to physicians when ordering the residents' therapeutic diets, had a place for "other" for diet selection.
-The diets listed on the therapeutic diets form were the diets the therapeutic menu should have included.

A second interview with the DM on 07/28/22 at 7:54am revealed:
-He reported to the Administrator.
-The Resident Care Coordinator (RCC) and Special Care Unit Coordinator (SCUC) provided

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him with the diet orders and he placed them in the kitchen.
-The RCC and SCUC would clarify any diet orders if needed.

Interview with the Resident Services Director (RSD) on 07/28/22 at 8:45am revealed:
-She started as the RSD on 07/18/22 and was still in training.
-She was not sure what the facility's procedure was for processing diet orders but in her experience the admission FL-2 should have the diet order.
-The primary care provider (PCP) would complete a diet order sheet and that would be faxed to the pharmacy and a copy of it would be sent to the kitchen for their files.

Interview with the Administrator on 07/28/22 at 8:20am revealed:
-He started as the administrator on 09/21/21.
-There were several positions vacant when he started including the DM.
-The facility's corporate office generated the weekly menus and the corresponding therapeutic diets.
-He knew the facility offered mechanical soft, puree, diabetic and no added salt diets.
-He had to cook for the facility during the hiring process of the new DM and was familiar with the specifics for the diets including the diet menus.
-He was familiar with the rule requiring the facility to have therapeutic diet menus to match the residents' physician's ordered therapeutic diets.
-He was not aware the forms the physicians were using to order therapeutic diets for the residents had an area for "other".

Interview with Resident #4's PCP's Registered Nurse (RN) on 07/28/22 at 9:30am revealed:

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D 296	Continued From page 18 -She did not recall ever receiving any calls from the facility regarding Resident #4. -The PCP had written a diet order on 06/27/22 for a low sugar, diabetic, low sodium diet. -Resident #4 was a diabetic and would need a diabetic diet. -There was nothing noted as to why Resident #4 needed a low sodium diet; no diagnosis that required that type of diet.	D 296		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 4 residents (#6, #7) observed during the medication pass including errors with two insulins and a medication used to prevent constipation (#7) and a medication used to prevent heart disease (#6); and for 1 of 5 residents sampled (#1) for record review including errors with a medication used to treat seizures, migraines or mood disorders and a medication used to prevent heart disease (#1). The findings are:	D 358		

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1. The medication error rate was 16% as evidenced by the observation of 4 errors out of 25 opportunities during the 8:00am medication pass on 07/27/22.

a. Review of Resident #7's current FL-2 dated 11/18/21 revealed:
-Diagnoses included diabetes mellitus type 2 and constipation.
-There was an order for Novolog Flexpen inject 12 units with breakfast and dinner. (Novolog is rapid-acting insulin used to lower blood sugar. The manufacturer recommends eating a meal within 5 to 10 minutes after the injection. The Novolog Flexpen should be primed with a 2-unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles. Once the needle is inserted into the skin, the dose knob should be pushed all the way in and held for at least 6 seconds to ensure the full amount is injected.)

Review of Resident #7's July 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Novolog Flexpen inject 12 units twice a day with breakfast and supper scheduled at 8:00am and 5:00pm.
-Novolog Flexpen was documented as administered from 07/01/22 - 07/27/22.
-The resident's blood sugar was checked twice a day at 8:00am and 8:00pm and ranged from 154 - 313 from 07/01/22 - 07/27/22.

Interview with the medication aide (MA) on 07/27/22 at 8:40am revealed:
-Resident #7 usually ate breakfast in her room.
-The personal care aides (PCAs) usually delivered breakfast to residents who ate in their

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rooms after residents who ate in the dining room finished breakfast.
-Resident #7 had not received her breakfast yet that morning on 07/27/22.
-She could not specify what time Resident #7's breakfast meal would be delivered that morning on 07/27/22.

Observation of the 8:00am medication pass on 07/27/22 revealed:
-Resident #7's blood sugar was 174 at 8:40am.
-The MA administered 12 units of Novolog insulin into Resident #7's right upper arm at 8:44am.
-The MA did not perform a 2-unit air shot prior to dialing the insulin pen to 12 units to ensure no air bubbles were present and to ensure insulin was flowing from the pen.
-The MA immediately removed the insulin pen from the skin as soon as the last click was heard when pressing the button.
-The MA did not hold the insulin pen in the skin after injecting the needle and pressing the button to allow time for the full amount of insulin to be injected.

Observation of Resident #7 on 07/27/22 from 8:44am - 9:22am revealed no breakfast meal was delivered to the resident.

Observation of the dining room on 07/27/22 at 9:23am revealed there were no residents or staff in the dining room and all tables had been cleaned.

Interview with Resident #7 on 07/27/22 at 9:35am revealed:
-She always ate breakfast in her room.
-She had not received breakfast that morning (07/27/22) yet.
-She sometimes had to wait until after 10:00am

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before she received her breakfast tray in her room.

Interview with the Administrator on 07/27/22 at 9:38am revealed he did not know why Resident #7 had not received her breakfast tray.

Observation on 07/27/22 at 9:42am revealed the Administrator delivered Resident #7's breakfast meal to her room, 58 minutes after the resident was administered Novolog insulin.

Interview with Resident #7 on 07/27/22 at 9:42am revealed:
-She usually got dizzy when her blood sugar was too low.
-She denied any current symptoms of dizziness.

A second interview with the MA on 07/27/22 at 11:51am revealed:
-Insulin ordered with meals could be administered at least 30 minutes prior to a meal.
-She also had 1 hour before and 1 after the scheduled time to administer medications to residents.
-She had training on the use of insulin pens but she could not recall when.
-She had never done an air shot when administering insulin with an insulin pen and she was not aware she needed to do an air shot.
-She had never held in the insulin pen after injecting because she was not aware she needed to hold it in.
-She pulled the insulin pen out of the resident's skin as soon as she heard the last click.

Interview with the Resident Services Coordinator (RSC) on 07/27/22 at 12:42pm revealed:
-Insulin ordered with meals should be administered within 30 minutes of the meal.

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-Resident #7 ate breakfast in her room and should be served breakfast no later than 8:30am.
-The MAs were supposed to keep snacks in the medication carts.
-The MAs should ask a resident if they were going to eat a meal or if the resident had not received their meal, the MA should have given the resident a snack when insulin was administered.
-The MAs had been trained on proper technique for use of insulin pens upon hire.
-The MAs had been instructed on performing air shots with insulin pens and they should hold the injection in for about 5 seconds.

Interview with the Resident Services Director (RSD) on 07/27/22 at 1:06pm revealed:
-She had just started working at the facility about 7 days ago so she was not sure of the facility's policy for insulin administration.
-The MAs should use proper technique when administering insulin with insulin pens, including a 2-unit air shot and holding the injection in to allow the full amount of insulin to be administered.

Interview with Resident #7's primary care provider (PCP) on 07/27/22 at 12:30pm revealed:
-Resident #7's Novolog insulin should be administered within 30 minutes of a meal to prevent low blood sugar that could potentially cause a fall.
-If the resident's meal would not be served within 30 minutes of receiving the Novolog insulin, a snack should be provided to the resident at the time the insulin was administered.

b. Review of Resident #7's current FL-2 dated 11/18/21 revealed an order for Tresiba FlexTouch pen inject 44 units daily at 8:00am. (Tresiba is a long-acting insulin analog used to lower blood sugar. The Tresiba FlexTouch pen should be

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primed with a 2-unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles. Once the needle is inserted into the skin, the dose knob should be pushed all the way in and held for at least 6 seconds to ensure the full amount is injected.)

Review of Resident #7's July 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Tresiba FlexTouch pen inject 44 units daily scheduled at 8:00am.
-The resident's blood sugar was checked twice a day at 8:00am and 8:00pm and ranged from 154 - 313 from 07/01/22 - 07/27/22.

Observation of the 8:00am medication pass on 07/27/22 revealed:
-Resident #7's blood sugar was 174 at 8:40am.
-The medication aide (MA) administered 44 units of Tresiba FlexTouch into Resident #7's right upper arm at 8:45am.
-The MA did not perform a 2-unit air shot prior to dialing the insulin pen to 44 units to ensure no air bubbles were present and to ensure insulin was flowing from the pen.
-The MA immediately removed the insulin pen from the skin as soon as the last click was heard when pressing the button.
-The MA did not hold the insulin pen in the skin after injecting the needle and pressing the button to allow time for the full amount of insulin to be injected.

Interview with the MA on 07/27/22 at 11:51am revealed:
-She had training on the use of insulin pens but she could not recall when.
-She had never done an air shot when administering insulin with an insulin pen and she

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was not aware she needed to do an air shot.
-She had never held in the insulin pen after injecting because she was not aware she needed to hold it in.
-She pulled the insulin pen out of the resident's skin as soon as she heard the last click.

Interview with the Resident Services Coordinator (RSC) on 07/27/22 at 12:42pm revealed:
-The MAs had been trained on proper technique for use of insulin pens upon hire.
-The MAs had been instructed on performing air shots with insulin pens and they should hold the injection in for about 5 seconds.

Interview with the Resident Services Director (RSD) on 07/27/22 at 1:06pm revealed the MAs should use proper technique when administering insulin with insulin pens, including a 2-unit air shot and holding the injection in to allow the full amount of insulin to be administered.

Interview with Resident #7's primary care provider (PCP) on 07/27/22 at 12:30pm revealed the MAs should use proper technique with administering insulin pens to make sure the correct amount of insulin was administered.

c. Review of Resident #7's current FL-2 dated 11/18/21 revealed an order for Miralax mix 17 grams (g) in suitable liquid and drink once daily. (Miralax is a laxative used to treat and prevent constipation. Miralax is a powder and the inside of the cap on the bottle has a marking for 17g that should be used to measure the dosage at the top of the white section of the cap.)

Observation of the 8:00am medication pass on 07/27/22 revealed:
-There was a white section lining the inside of the

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purple cap on the Miralax bottle.
-There was "17 g" imprinted near the top of the white section and an arrow pointing up to indicate the measurement for 17g was at the top of the white section inside the cap.
-The medication aide (MA) poured the Miralax powder to the top of the purple cap about ¼ inch above the marking for 17g dose.
-The MA did not measure the Miralax correctly and the full dosage was not mixed in the cup of water.
-The MA mixed the Miralax powder in water and gave it to Resident #7 in her room at 9:07am.
-The resident told the MA that she would take the Miralax after she ate breakfast.
-The MA left the cup with Miralax sitting on the table beside the resident's recliner.

Review of Resident #7's July 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Miralax mix 17g in suitable liquid and drink once daily scheduled for 8:00am.
-Miralax was documented as administered daily at 8:00am from 07/01/22 - 07/27/22.

Observation of Resident #7's room on 07/27/22 at 10:03am revealed the full cup of Miralax was still sitting on the table beside the resident's recliner.

Interview with Resident #7 on 07/27/22 at 10:03am revealed:
-She ate breakfast in her room and she had just finished eating.
-She had not taken the Miralax yet and she was trying to decide if she wanted to take the Miralax before or after she took a shower.
-The MA had not checked to see if she had taken the Miralax.

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D 358	Continued From page 26 -She denied any current issues with constipation or diarrhea. Observation of Resident #7's room on 07/27/22 at 11:45am revealed: -The full cup of Miralax was sitting on the counter near the end of the resident's bed. -None of the water with Miralax had been drank. Interview with Resident #7 on 07/27/22 at 11:45am revealed: -She moved the Miralax to the counter near the end of her bed. -She had not taken the Miralax yet. -She might take the Miralax after she ate lunch today, but she was not sure if she was going to take it. -The MA had not checked to see if she had taken the Miralax. Interview with the MA on 07/27/22 at 11:51am revealed: -She usually observed Resident #7 take the Miralax but today the resident wanted to wait and take it later. -She thought it was okay to leave the Miralax in the resident's room because it was liquid. -She went back to the resident's room that morning (could not say what time) and she thought the resident had taken the Miralax because she saw an empty cup in the resident's trash can. -The MA had no explanation when she was told the Miralax was still in the resident's room at 11:45am and had not been taken. Interview with the RSC on 07/27/22 at 12:42pm revealed: -The MAs had been trained on how to properly measure medications.	D 358		

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-The MAs should use the marking on the inner cap of the Miralax bottle to measure the 17g dose.
-The MAs knew they were supposed to actually observe a resident take their medication prior to documenting the medication was administered on the eMAR.

Interview with Resident #7's primary care provider (PCP) on 07/27/22 at 12:30pm revealed:
-If Resident #7's Miralax was measured incorrectly with too much on a scheduled basis, it could cause diarrhea.
-Not receiving the Miralax as ordered could cause constipation.

d. Review of Resident #6's current FL-2 dated 03/24/22 revealed:
-Diagnoses included Alzheimer's disease, coronary artery disease, primary hypertension, and depression.
-There was an order for Aspirin 81mg 1 tablet daily. (Aspirin is used to prevent heart disease.)

Review of Resident #6's primary care provider (PCP) orders dated 06/01/22 revealed an order to discontinue Aspirin 81mg daily.

Observation of the 8:00am medication pass on 07/27/22 revealed the medication aide (MA) administered one Aspirin 81mg tablet to Resident #6 at 7:48am when she received her other morning medications scheduled for 8:00am.

Review of Resident #6's June 2022 and July 2022 electronic medication administration records (eMARs) revealed:
-There was an entry for Aspirin 81mg 1 tablet daily scheduled at 8:00am on the June 2022 and July 2022 eMARs.

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-There was no entry to discontinue Aspirin 81mg on 06/01/22 as ordered by the PCP.
-There was documentation the resident continued to be administered Aspirin 81mg daily from 06/01/22 - 07/27/22 after the order had been discontinued.

Observation of Resident #6's medications on hand on 07/27/22 at 12:15pm revealed:
-There was a medication card with a supply of Aspirin 81mg tablets dated 07/05/22.
-There were 9 of 30 tablets of Aspirin 81mg remaining in the medication card.

Interview with the MA on 07/27/22 at 12:12pm revealed:
-She administered Aspirin to Resident #6 during the morning medication pass because Aspirin was listed on the eMAR to be administered with the other 8:00am medications.
-She was not aware the order for Aspirin had been discontinued.

Interview with the Special Care Unit Coordinator (SCUC) on 07/27/22 at 12:20pm revealed:
-She was on leave for a couple of weeks around the first part of June 2022 so she did not see the order dated 06/01/22 to discontinue Resident #6's Aspirin.
-The Resident Services Coordinator (RSC) was responsible for processing medication orders during that time.
10pm revealed:
-She did not recall seeing the order to discontinue Resident #1's Aspirin dated 06/01/22.
-Either she or the SCUC were responsible for faxing the discontinue order to the pharmacy.
-The pharmacy entered orders into the eMAR system, including discontinue orders.
-She or the SCUC approved orders in the eMAR

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system once the orders were entered by the pharmacy.
-The order to discontinue Resident #6's Aspirin must have been overlooked.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 07/28/22 at 9:40am revealed:
-The pharmacy entered orders, including discontinue orders, into the eMAR system when the order was received from the facility.
-The pharmacy did not receive the order to discontinue Resident #6's Aspirin dated 06/01/22.
-The pharmacy dispensed a month supply of Aspirin on 01/03/22, 02/2/22, 03/01/22, 04/04/22, 05/02/22, 05/29/22, and 06/29/22.
-The supply dispensed on 06/29/22 had a cycle start date of 07/05/22 (the current supply on hand).

Interview with Resident #6's PCP on 07/27/22 at 12:21pm revealed:
-She wrote an order on 06/01/22 to discontinue Resident #6's Aspirin.
-Aspirin was not indicated for Resident #6 due to her age and the risk of a brain bleed with a fall.
-The Aspirin should have been discontinued as ordered on 06/01/22.

2. Review of Resident #1's current FL-2 dated 07/26/22 revealed diagnoses of major depressive disorder, vitamin D deficiency, anxiety and dementia.

Review of Resident #1's signed physician's consultation orders dated 05/25/22 revealed an order to discontinue aspirin 325mg daily. (Aspirin is used to treat pain, fever, headache and inflammation).

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Review of Resident #1's May 2022 electronic medication administration record (eMAR) on 07/26/22 at 3:18pm reveled:
-There was an entry for aspirin 325mg to be administered daily at 8:00am.
-Aspirin 325mg tablet was documented as administered 05/26/22- 05/31/22.
-There was no entry after 05/25/22 to discontinue Aspirin 325mg.

Review of Resident #1's June 2022 eMAR on 07/26/22 at 3:18pm reveled:
-There was an entry for aspirin 325mg to be administered daily at 8:00am.
-Aspirin 325mg tablet was documented as administered 06/01/22- 06/30/22.
-There was no entry after 05/25/22 to discontinue Aspirin 325mg.

Review of Resident #1's July 2022 eMAR on 07/26/22 at 3:18pm reveled:
-There was an entry for aspirin 325mg to be administered daily at 8:00am.
-Aspirin 325mg tablet was documented as administered 07/01/22- 07/26/22.
-There was no entry after 05/25/22 to discontinue Aspirin 325mg.

Observation of the Resident #1's medication on hand on 07/26/22 at 3:57pm revealed Aspirin 325mg tablet was in the medication cart.

Refer to Interview with the Resident Services Coordinator (RSC) on 07/26/22 at 9:45am.

Interview with the Primary Care Provider (PCP) on 07/27/22 at 9:21am revealed:
-She discontinued Aspirin 325mg tablet because it placed Resident #1 at risk for increase bleeding.

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-If Resident #1 fell, the fall could potentially cause a brain bleed because the blood would not be able to clot.
-Aspirin 325mg tablet was not appropriate for daily use.

Refer to interview with the PCP on 07/27/22 at 9:21am.

Refer to interview with the Administrator on 07/27/22 at 10:06am

b. Review of Resident #1's signed physician's consultation orders dated 05/25/22 revealed an order to discontinue topiramate 25mg daily. (Topiramate is used to treat and prevent seizures. It can also prevent migraine headaches).

Review of Resident #1's May 2022 eMAR on 07/26/22 at 3:18pm reveled:
-There was an entry for Topiramate 25mg to be administered daily at 8:00am.
-Topiramate 25mg tablet was documented as administered 05/26/22- 05/31/22.
-There was no entry after 05/25/22 to discontinue Topiramate.

Review of Resident #1's June 2022 eMAR on 07/26/22 at 3:18pm reveled:
-There was an entry for Topiramate 25mg to be administered daily at 8:00am.
-Topiramate 25mg tablet was documented as administered 06/01/22- 06/30/22.
-There was no entry after 05/25/22 to discontinue Topiramate.

Review of Resident #1's July 2022 eMAR on 07/26/22 at 3:18pm reveled:
-There was an entry for Topiramate 25mg to be administered daily at 8:00am.

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D 358	Continued From page 32 -Topiramate 25mg tablet was documented as administered 07/01/22- 07/26/22. -There was no entry after 05/25/22 to discontinue Topiramate. Observation of Resident #1 's medications on hand on 07/26/22 at 3:57pm revealed Topiramate 25mg tablet was in the medication cart. Refer to interview with the RSC on 07/26/22 at 9:45am. Interview with the PCP on 07/27/22 at 9:21am revealed: -She discontinued Topiramate 25mg because there was no reason for Resident #1 to be prescribed the medication. -Resident #1 had no history of headaches nor seizures. Refer to interview with the PCP on 07/27/22 at 9:21am. Refer to interview with the Administrator on 07/27/22 at 10:06am _____ Interview with the RSC on 07/26/22 at 9:45am revealed: -She conducted medication cart audits monthly. -She conducted record review audits quarterly. -The medication aides (MAs) were responsible for ensuring the medication orders were sent to the pharmacy. -After orders were sent to the pharmacy, the MAs placed the confirmation faxes in the RSC's mailbox and removed the medications from the medication cart. -The RSC and MAs were responsible to ensure the medications were removed from the cart.	D 358		

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D 358	Continued From page 33 -She was not aware the Aspirin and Topiramate for Resident #1 was discontinued. Interview with the PCP on 07/27/22 at 9:21am revealed: -The combination of Aspirin and Topiramate were not a good outcome for Resident #1. -When she wrote the orders for Aspirin and Topiramate, she expected the facility to discontinue administering the medications. -She was concerned about the risk for Resident #1 while taking both medications. Interview with the Administrator on 07/27/22 at 10:06am revealed: -He was not aware the Aspirin and Topiramate for Resident #1 was discontinued. -He expected the RSC or MA to process medication orders. -Discontinued medication orders were processed by the MA, RSC or Resident Service Director (RSD) and sent to the pharmacy. -The RSC and the MAs were responsible to ensure the medications in the medication cart were removed when orders were discontinued. _____ The facility failed to administered medications as ordered to two residents observed during the medication pass on 07/27/22. Resident #7 received a rapid-acting insulin 58 minutes before the breakfast meal putting the resident at risk of having symptoms of low blood sugar. The MA did not use proper technique for insulin pens when administering two insulins to Resident #7 including failure to hold the injections in for 6 seconds to ensure the full amount of insulin was administered. Resident #6 was administered Aspirin during the medication pass on 07/27/22 that should have been discontinued on 06/01/22	D 358		

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D 358	Continued From page 34 putting the resident at risk of a brain bleed if she had fallen according to the PCP. Resident #1 continued to received Aspirin and Topiramate when both medications should have been discontinued on 05/25/22, putting the resident at risk of side effects from those medications. This failure 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 07/27/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 11, 2022.	D 358		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure follow up on medication review recommendations for 2 of 4 sampled residents (#4, #5) related to medications for heart failure, underactive thyroid disease, and ulcers (#5) and for failure to document and notify the primary care provider (PCP) of blood sugars	D 406		

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D 406	Continued From page 35 greater than 150 (#4). The findings are: 1. Review of Resident #5's current FL-2 dated 08/13/21 revealed: -Diagnoses included dementia, congestive heart failure, chronic kidney disease III, hypertension, and hypothyroidism. -There was an order for Levothyroxine, (used to treat underactive thyroid disease), 100mcg one tablet every morning. -There was an order for Vyndamax, (used to treat heart failure), 61mg one a day. -There was an order for Sucralfate suspension, (used to treat and prevent ulcers of the intestines), one gram twice a day. Review of Resident #5's Resident Register revealed he was admitted to the facility on 08/25/21. Review of Resident #5's medication review dated 02/23/22 revealed: -The pharmacist recommended for the administration time of Levothyroxine to be 30-60 minutes prior to medications/foods. -The pharmacist documented Vyndamax was suspended from the electronic medication administration record (eMAR) 12/18/21 - 12/22/21 with notation "awaiting order for medication". -There was no documentation by the facility that the prescriber had received, followed, or refused the recommendations. Review of Resident #5's medication review dated 05/23/22 revealed: -The pharmacist recommended for the administration time of Levothyroxine to be 30-60 minutes prior to medications/foods.	D 406		

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D 406	Continued From page 36 -The pharmacist recommended changing the administration time of Sucralfate to 2 hours away from other medications to not alter absorption of other medications. -There was no documentation by the facility that the prescriber had received, followed, or refused the recommendations. Review of Resident #5's May 2022 eMAR revealed: -There was an entry for Levothyroxine 100mcg to be administered every morning at 8:00am. -There was documentation Levothyroxine was administered at 8:00am from 05/01/22 - 05/31/22. -There was an entry for Sucralfate suspension 1GM/10ml to be administered two times a day at 8:00am and 8:00pm. -There was documentation Sucralfate was administered at 8:00am and 8:00pm from 05/01/22 - 05/31/22. -There was an entry for Vyndamax 61mg to be administered daily at 8:00am. -There was documentation Vyndamax was administered at 8:00am from 05/01/22 - 05/31/22. Review of Resident #5's June 2022 eMAR revealed: -There was an entry for Levothyroxine 100mcg to be administered every morning at 8:00am. -There was documentation Levothyroxine was administered at 8:00am from 06/01/22 - 06/30/22. -There was an entry for Sucralfate suspension 1GM/10ml to be administered two times a day at 8:00am and 8:00pm. -There was documentation Sucralfate was administered at 8:00am and 8:00pm from 06/01/22 - 06/30/22. -There was an entry for Vyndamax 61mg to be administered daily at 8:00am. -There was documentation Vyndamax was	D 406		

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administered at 8:00am from 06/01/22 - 06/30/22.

Review of Resident #5's July 2022 eMAR revealed:
-There was an entry for Levothyroxine 100mcg to be administered every morning at 8:00am.
-There was documentation Levothyroxine 100mcg was administered at 8:00am from 07/01/22 - 07/14/22.
-There was an entry for Levothyroxine 88mcg to be administered every morning at 6:30am on 07/15/22.
-There was documentation Levothyroxine 88mcg was administered at 8:00am from 07/15/22 - 07/26/22.
-There was an entry for Sucralfate suspension 1GM/10ml to be administered two times a day at 8:00am and 8:00pm.
-There was documentation Sucralfate was administered at 8:00am and 8:00pm from 07/01/22 - 07/26/22.
-There was an entry for Vyndamax 61mg to be administered daily at 8:00am through 07/15/22 and then it was discontinued.
-There was documentation Vyndamax 61mg was administered daily at 8:00am through 07/15/22 and then it was discontinued.

Review of Resident #5's medical record revealed:
-There was no documentation the pharmacist's recommendations from February 2022 and May 2022 had been forwarded to the primary care provider (PCP).
-There were no orders from the PCP that addressed the pharmacist's recommendations for February 2022 and May 2022.

Interview with Resident #5's PCP on 07/27/22 at 9:20am revealed:
-She started as the PCP for the facility on

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05/25/22.
-She was not the PCP who ordered the medications for which the pharmacist had made the recommendations for Resident #5's medication reviews for February 2022 and May 2022.
-She would expect the facility to notify the PCP of record during February 2022 and May 2022 for the pharmacist's recommendations.
-She did not feel comfortable making changes to Resident #5's medications that she had not ordered especially without first examining and knowing the resident.

Refer to interview with the Resident Services Director (RSD) on 07/28/22 at 8:45am.

Refer to interview with the Administrator on 07/28/22 at 8:00am.

2. Review of Resident #4's current FL-2 dated 06/27/22 revealed:
-Diagnoses included Alzheimer's dementia and type 2 diabetes mellitus.
-There was an order to check and record blood sugar twice a day, notify primary care provider (PCP) if blood sugar was less than 70 or greater than 150.

Review of Resident #4's medication review dated 02/28/22 revealed:
-The pharmacist noted the resident's blood sugar had been greater than 150 on 29 occasions from December 2021 - February 2022 but there was no documentation the PCP had been notified.
-The pharmacist asked if the provider had been notified.
-There was no documented response to the pharmacist's recommendation.

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(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 406	Continued From page 39	D 406		

Review of Resident #4's medication review dated 05/23/22 revealed:
-The pharmacist noted the resident's blood sugar had been greater than 150 on 55 occasions from March 2022 - May 2022 but there was no documentation the PCP had been notified.
-The pharmacist asked if the provider had been notified.
-There was no documented response to the pharmacist's recommendation.

Review of Resident #4's facility progress notes and care provider notification forms for 2022 revealed no documentation the pharmacist's recommendations for February 2022 and May 2022 had been forwarded to the PCP.

Review of Resident #4's May 2022 - July 2022 electronic medication administration records (eMARs) revealed:
-There were entries to check and record blood sugar twice a day, notify provider if blood sugar was less than 70 or greater than 150.
-The resident's blood sugar was scheduled to be checked at 7:30am and 4:30pm.
-The resident's blood sugar was documented as greater than 150 on 52 occasions ranging from 151 - 241 and there was no documentation the resident's PCP was notified.

Interview with a medication aide (MA) on 07/26/22 at 4:13pm revealed if she had contacted Resident #4's PCP when the resident's blood sugar was greater than 150, it would be noted in the eMAR system or the electronic progress notes.

Interview with a second MA on 07/27/22 at 10:10am revealed:
-The MAs could call or fax the PCP for any blood

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	HAL09214	A. BUILDING: _____ B. WING _____	R 07/28/2022

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sugar readings outside of the ordered parameters.
-After reviewing the eMAR, she did not realize the ordered parameter was to contact the PCP when the blood sugar was greater than 150.
-She never contacted the PCP because she thought the parameter was to contact the PCP if the resident's blood sugar was greater than 500.

Interview with the SCUC on 07/27/22 at 10:30am revealed:
-The MAs should notify the PCP of blood sugar readings outside of the ordered parameters.
-She faxed the last 6 months of Resident #4's blood sugar readings to the PCP on 07/26/22.

Interview with the Administrator on 07/26/22 at 4:28pm revealed:
-There was no documentation that Resident #4's PCP had been notified of blood sugar readings greater than 150.
-He did not know if Resident #4's medication review recommendations for February 2022 and May 2022 had been faxed to the resident's PCP.
-The Special Care Unit Coordinator (SCUC) just faxed Resident #4's blood sugar readings for the last 6 months to the PCP this afternoon (07/26/22) based on the medication review recommendation.

Refer to interview with the Resident Services Director (RSD) on 07/28/22 at 8:45am.

Refer to interview with the Administrator on 07/28/22 at 8:00am.

Interview with the Resident Services Director (RSD) on 07/28/22 at 8:45am revealed:
-She started as the RSD on 07/18/22 and was

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still in training.
-She was not sure what the facility's procedure was for processing medication reviews.
-The facility's current contracted PCP was new and was not comfortable making adjustments on recommendations based on the previous PCP's orders.
-Going forward the medication reviews would come to her and she and the Resident Care Coordinator (RCC) and the Special Care Unit Coordinator (SCUC) would work on following up and implementing those recommendations.

Interview with the Administrator on 07/28/22 at 8:00am revealed:
-The Consultant Pharmacist usually sent the medication review recommendations via email to him, the RCC, the SCUC, and the RSD.
-The RCC, SCUC, and RSD were responsible for following up on the medication reviews by getting the recommendations to the resident's PCP and then implementing any orders based on the PCP's response.
-For residents seen by the facility's contracted PCP, the medication review recommendations should be put in the contracted PCP's folder for review during weekly visits to the facility.
-For an outside PCP, the medication review recommendations would be faxed or emailed.
-The facility had some recent vacancies in the RCC, SCUC, and RSD positions that may have contributed to the medication reviews not being followed up.
-The medication review recommendations for February 2022 and March 2022 should have been forwarded to the residents' PCPs and followed up when they were received.
-The new check and balance system would include the RSD checking behind the RCC and SCUC to make sure medication reviews were

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D 406	Continued From page 42 followed up and implemented. Attempted telephone interview with the Consultant Pharmacist on 07/28/22 at 9:44am was unsuccessful.	D 406		
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, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to personal care and supervision and medication administration. The findings are: 1. Based on observations, interviews, and record reviews the facility failed to provide supervision for 1 of 1 sampled resident (#2) who was known to be forgetful and required extensive staff assistance and had a history of falls resulting in multiple falls and closed head injury with extensive facial bruising and skin tears on both arms. [Refer to Tag D270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)]. 2. Based on observations, interviews, and record	D912		

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D912	Continued From page 43 reviews, the facility failed to administer medications as ordered for 2 of 4 residents (#6, #7) observed during the medication pass including errors with two insulins and a medication used to prevent constipation (#7) and a medication used to prevent heart disease (#6); and for 1 of 5 residents sampled (#1) for record review including errors with a medication used to treat seizures, migraines or mood disorders and a medication used to prevent heart disease (#1). [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		