STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026068	A. BUILDING: _____ B. WING _____	R-C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FAYETTEVILLE	1164 71ST SCHOOL ROAD CUMBERLAND, NC 28331

(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 conducted a follow-up survey on December 14, 2021 - December 15, 2021.	{D 000}		
{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 interviews and record reviews, the facility failed to ensure referrals related to orders for physical therapy and speech therapy were implemented for 1 of 5 sampled residents (#2). The findings are: Review of Resident #2's current FL-2 dated 09/09/21 revealed: -Diagnoses included adjustment insomnia, repeated falls, muscle weakness (generalized), other lack of coordination, cognitive communication deficit, dementia without behavioral disturbance, restlessness and agitation. -There was an order for physical and speech therapy to evaluate and treat. Review of staff progress notes dated 10/11/21 through 11/04/21 revealed: -On 10/14/21 at 12pm, staff documented "resident had no c/o (complaints of) pain, following up on recent fall incident." -On 10/25/21 at 6:15am, staff documented "while using the bathroom, [Resident #2 named] was exiting when she fell."	{D 273}		

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{D 273}	Continued From page 1 Interview with the HWD on 12/14/21 at 3:38pm revealed if Resident #2 received a physical therapy evaluation, the results would not be in the resident's record and he would have to research the status of the physical therapy evaluation. Interview with Resident #2's first former PCP on 12/15/21 at 4:30pm revealed: -He completed Resident #2's FL-2 prior to her transfer to the facility. -Once a resident was transferred to the new facility, there was a transition of care to the new PCP. -Resident's orders including medication orders would be considered the new facility's responsibility to implement. -He imagined Resident #2 already had received physical therapy at rehab prior to transferring to the new facility. -He thought Resident #2's order for a physical therapy was standard orders upon transfer. -He thought the new facility would have their own on-site therapy team and would have evaluated Resident #2 and provided recommendations. Interview with the Health and Wellness Director (HWD) on 12/14/21 at 3:38pm revealed if Resident #2 received physical and speech therapy evaluation, the results would not be in the resident's record and he would have to research the status of the evaluations. Interview with Resident #2's former Primary Care Provider (PCP) on 12/15/21 at 4:30pm revealed: -He completed Resident #2's FL-2 prior to her transfer to the facility. -Once a resident was transferred to the new facility, there was a transition of care to the new	{D 273}		

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{D 273}	Continued From page 2 PCP. -Residents' orders including medication orders would be considered the new facility's responsibility to implement. -He thought Resident #2's order for a physical and speech therapy evaluation was a standard order upon transfer. -He thought the new facility would have their own on-site therapy team and would have evaluated Resident #2 and provided recommendations. Interview with the Executive Director (ED) on 12/15/21 at 11:29am revealed: -Upon admission, Resident #2's FL-2 would have gone to her first then she would have given the FL-2 to the Resident Care Coordinator (RCC). -The RCC would be responsible to process the primary care provider PCP's orders on the FL-2 and schedule any appointments, for example, physical therapy or a speech evaluation. Interview with the RCC on 12/15/21 at 3:31pm revealed: -She worked as the RCC at the facility for about 6 months. -Her responsibilities included assisting the Health Wellness Director (HWD). -She filed orders and paperwork from the residents' PCP. -She was also responsible for processing the PCP's orders on the resident's FL-2, for example, orders for physical therapy and speech therapy evaluation. -A resident's order for speech/physical therapy would be sent to an outside home health agency within a week. -The facility's process was to ensure there were no PCP's orders missed. -The HWD and the RCC would check behind each other.	{D 273}		

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{D 273}	Continued From page 3 -She did not recall seeing Resident #2's orders for physical therapy or her order for a speech evaluation. -Resident #2's orders for physical therapy and her speech evaluation were not implemented by her. -Resident #2's did have some falls (maybe 2) that she was aware of, but she did not think Resident #2 had gone to the hospital after either fall. Second interview with the ED on 12/15/21 at 3:31pm revealed: -The RCC was responsible to process new orders for residents. -She expected the RCC to implement new orders as quick as possible which meant within a 48-hour timeframe. -Upon admission to the facility, Resident #2's FL-2 was given to the RCC. -It was the RCC's responsibility to follow up with scheduling Resident #2's physical therapy and speech evaluation. -She was not aware the RCC did not schedule Resident #2's physical therapy or speech evaluation. -It must have been an oversight. -Resident #2 had a fall and she fractured her finger. -An imaging test of Resident #2's left hand revealed a fracture of the left 5th (pinky) finger. No speech therapy evaluation or speech therapy notes were provided for review. Based on observations, interviews and record review it was determined Resident #2 was not interviewable	{D 273}		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care	D 276		

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D 276	Continued From page 4 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: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure physician orders for accuchecks was implemented for 1 of 5 sampled residents (#2). The findings are: Review of Resident #2's current FL-2 dated 09/09/21 revealed: -Diagnoses included type 2 diabetes mellitus without complications,adjustment, cognitive communication deficit, dementia without behavioral disturbance, and essential hypertension. -There were three pages of the FL-2 that included physician orders for medications and treatments. Review of the Resident Register for Resident #2 dated 09/08/2021 revealed: -An admission date to the facility of 09/09/2021. -A discharge date from the facility to home of 09/30/21. Review of a facility progress note dated 10/11/21 revealed Resident #2 was transported from home	D 276		

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D 276	Continued From page 5	D 276		

back to the facility by facility staff.
a. Review of physician orders for Resident #2 revealed:
-There was an order for accuchecks (fingerstick blood sugar checks) before meals and at bedtime dated 09/09/21.
-There was a subsequent physician's order dated 11/22/21 for fingerstick blood sugar checks daily before breakfast.
-There was a physician's order dated 09/09/21 for Metformin (used to lower blood sugar) 1000mg twice daily.
-There was a physician's order dated 09/09/21 for Pioglitazone (used to control high blood sugar) 30mg tablet daily.
-There was a subsequent order dated 12/09/21 for daily Lantus insulin, and sliding scale insulin coverage subcutaneously three times daily. The diagnosis documented was "elevated A1C/diabetes mellitus II".

Review of Resident #2's October 2021 electronic medication administration records (eMARs) revealed:
-There was no entry transcribed to the eMARs for fingerstick blood sugar (FSBS) checks before meals and at bedtime.
-There was no documentation for FSBS checks.

Review of Resident #2's November 2021 eMARs revealed:
-There was no entry transcribed to the eMARs FSBS checks before meals and at bedtime.
-There was no entry transcribed to the eMARs FSBS checks before breakfast.
-There was no documentation for FSBS checks.

Review of Resident #2's December 2021 eMARs revealed:
-The first documented FSBS reading result was

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D 276	Continued From page 6	D 276		

317 documented at 7:00am on 12/02/21.
-The FSBS reading results ranged from 187 to 400 from 12/02/21 through 12/14/21.

Interview with the Health and Wellness Director (HWD) on 12/15/21 at 11:13am revealed:
-All department heads which included the Business Office Manager (BOM), the Executive Director (ED), the Resident Care Coordinator (RCC), and himself all had access to the facility's fax machine and could review a resident's interdisciplinary group (IDG) meeting notes.
-The facility's contracted pharmacy would add the new orders to the resident's electronic medication administration record (eMARs) for the facility to approve.

Interview with Resident #2's second former PCP on 12/15/21 at 3:01pm revealed:
-Resident #2 was transferred to her care in November 2021.
-She had signed the physician order review dated 11/04/21 to provide a continuation of care knowing Resident #2 would be coming to her office for a face-to-face visit on 12/02/21.
-Resident #2's first visit to her office was 12/02/21.
-She was not aware of Resident #2's fingerstick blood sugars, she had ordered lab work for Resident #2 on 12/02/21 but had not seen any results.
-There were concerns that Resident #2's fingerstick blood sugars (FSBS) were not being monitored as ordered.
-Resident #2 was a known diabetic and her FSBS could have been too high or too low.
-If Resident #2's FSBS were not monitored as ordered this could result in falls, syncope, light headedness, diabetic ketoacidosis, and encephalopathy (diabetic ketoacidosis is a

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D 276	Continued From page 7 serious diabetes complication where the body produces excess blood acids/ketones and encephalopathy is a disease that affects the brain). -Resident #2 did not have any recent hospitalizations but she did have a history of falls. Interview with Resident #2's first former PCP on 12/15/21 at 4:30pm revealed Resident #2 was supposed to have her fingerstick blood sugars monitored as ordered. Refer to the interview with the Executive Director/Administrator (ED) dated 12/15/21 at 11:29am. Refer to the interview with the Resident Care Coordinator dated 12/15/21 at 3:31pm. Refer to the interview with the Health and Wellness Director (HWD) dated 12/15/21 at 3:51pm. Refer to the interview with the Executive Director/Administrator (ED) dated 12/15/21 at 4:40pm. _____ Interview with the Executive Director (ED) on 12/15/21 at 11:29am revealed: -Upon admission, Resident #2's FL-2 would have gone to her first then she would have given the FL-2 to the Resident Care Coordinator (RCC). -The RCC would then be responsible to send the FL-2 to the facility's contracted pharmacy for order entry to the eMARs. Interview with the RCC on 12/15/21 at 3:31pm revealed: -She worked as the RCC at the facility for about 6	D 276		

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D 276	Continued From page 8	D 276		

months.
-Her responsibilities included assisting the Health Wellness Director (HWD) with the medication cart audits.
-She filed orders and paperwork from the residents' care provider (PCP).
-She had no role with resident admissions except to send the resident's FL-2 and the resident's pharmacy agreement to the facility's contracted pharmacy.
-The facility's process was to ensure there were no PCP's orders missed.
-The HWD and the RCC would check behind each other.

Second interview with the ED on 12/15/21 at 3:31pm revealed:
-The RCC was responsible to process new orders for residents.
-She expected the RCC to implement new orders as quick as possible which meant within a 48-hour timeframe.
-Upon admission to the facility, Resident #2's FL-2 was given to the RCC.
-Resident #2 had a fall and she fractured her finger.
-She was not aware the last 2 pages of Resident #2's FL-2 were not faxed to the facility's contracted pharmacy.
-Resident #2 could have had a diabetic issue or had a serious fall.

Based on observations, interviews and record review it was determined Resident #2 was not interviewable.

_____

The facility failed to ensure physician orders were implemented for 1 of 5 residents (#2) with orders for fingerstick blood sugar check with known diabetes mellitus thereby increasing the risk of

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D 276	Continued From page 9 high and low blood sugar levels. The facility's failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G S 131D-34 on 12/15/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 29, 2022.	D 276		
{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: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Non-compliance continues. Based on observations, record review, and interviews, the facility failed to administer medications as ordered by a prescribing practitioner to 1 of 5 sampled residents (#2), including medications used for treatment in lowering blood sugars, anxiety and agitation,	{D 358}		

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{D 358}	Continued From page 10 sleep disorders, and a dietary supplement. The findings are: Review of Resident #2's current FL-2 dated 09/09/21 revealed: -Diagnoses included adjustment insomnia, repeated falls, muscle weakness generalized, other lack of coordination, cognitive communication deficit, dementia without behavioral disturbance, restlessness and agitation, essential hypertension, hyperlipidemia, osteoarthritis, type 2 diabetes mellitus without complications, and hypokalemia. -There were three pages of the FL-2 that included physician orders from Resident #2's first former PCP for medications and treatments. Review of the Resident Register for Resident #2 dated 09/08/2021 revealed: -An admission date to the facility of 09/09/2021. -A discharge date from the facility to home of 09/30/21. Review of a facility progress note dated 10/11/21 revealed Resident #2 was transported from home back to the facility by facility staff. a. Review of physician orders for Resident #2 revealed: -There was a physician's order on the current FL-2 dated 09/09/21 for Insulin ASP Prt-Insulin Aspart Pen (generic for Novolog Mix 70-30 Insulin which is a combination of intermediate and rapid acting insulin used to control high blood sugars) 4 units subcutaneously before meals. -There were no subsequent physician orders discontinuing the Novolog Mix 70-30 Insulin 4 units subcutaneously before meals. -There was a Physician Order Review dated	{D 358}		

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{D 358}	Continued From page 11 11/04/21 by a second former PCP. -There was not a physician's order on the 11/04/21 physician order review for Novolog Mix 70-30 Insulin. Review of the October 2021 and November 2021 electronic medication administration records (eMARs) for Resident #2 revealed: -There was no entry for the Novolog Mix 70-30 Insulin 4 units subcutaneously before meals. -There was no documentation of administration for the Novolog Mix 70-30 Insulin 4 units before meals. Review of the December 2021 eMARs for Resident #2 revealed: -There was no entry for the Novolog Mix 70-30 Insulin 4 units subcutaneously before meals. -There was no documentation of administration for the Novolog Mix 70-30 Insulin 4 units before meals. -There was an entry for the Novolog Flexpen Insulin Aspart 3 units subcutaneous three times a day before meals with a start date of 12/03/21. Review of the contracted pharmacy dispensing history for Resident #2 dated 09/23/21 through 12/13/21 revealed Novolog Flexpen Insulin Aspart was dispensed to the facility on 12/02/21. Review of the Blood Glucose/Insulin Administration Report provided for Resident #2 revealed: -There were blood glucose results beginning 12/02/21 through 12/14/21. -The blood glucose results ranged from 187 to 400, with the first documented blood glucose result of 317 on 12/02/21 at 7:00am. -The second and highest documented blood glucose result was 400 on 12/03/21 at 4:30pm.	{D 358}		

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{D 358}	Continued From page 12 Review of a physician's order for Resident #2 dated 12/09/21 revealed there was a physician's order from the current PCP to start Lantus insulin 7 units at bedtime and give insulin lispro per sliding scale three times daily subcutaneously with diagnoses documented as elevated A1C/diabetes mellitus. The resulting A1C was not documented. Telephone interview with the second former PCP for Resident #2 at 3:01pm on 12/15/21 revealed: -There were concerns that Resident #2's Novolog insulin was not administered as ordered. -Resident #2's Novolog insulin should have been administered as ordered to avoid her having hyperglycemia which could result in the resident experiencing diabetic ketoacidosis (Hyperglycemia is a high blood sugar and diabetic ketoacidosis is a serious complication of diabetes that occurs when your body produces high levels of blood acids called ketones.) Refer to the interview with the Health and Wellness Director (HWD) on 12/15/21 at 11:13am. Refer to the telephone interview with the contracted pharmacy on 12/15/21 at 4:57pm. Refer to the interview with the Executive Director/Administrator (ED) on 12/15/21 at 11:29am. Refer to the second interview with the Health and Wellness Director on 12/15/21 at 2:40pm. Refer to the interview with the medication aide on 12/15/21 at 2:45pm.	{D 358}		

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{D 358}	Continued From page 13 Refer to the interview with the second former PCP for Resident #2 on 12/15/21 at 3:01pm. Refer to the interview with the Resident Care Coordinator (RCC) on 12/15/21 at 3:31pm. Refer to the third interview with the HWD on 12/15/21 at 3:51pm. Refer to the second interview with the ED on 12/15/21 at 3:31pm. Refer to the interview with the first former PCP for Resident #2 on 12/15/21 at 4:30pm. b. Review of physician orders for Resident #2 revealed: -There was a physician's order on the current FL-2 dated 09/09/21 for Lantus insulin (a long acting insulin used to control high blood sugars) 24 units subcutaneously at bedtime. -There were no subsequent physician orders discontinuing the Lantus Insulin 24 units subcutaneously at bedtime. -There was a Physician Order Review dated 11/04/21 by the second former PCP. -There was not a physician's order on the 11/04/21 physician order review for the Lantus Insulin 24 units at bedtime. Review of the October 2021, November 2021, and December 2021 eMARs for Resident #2 revealed: -There was no entry for the Lantus Insulin 24 units subcutaneously at bedtime. -There was no documentation of administration for Lantus Insulin 24 units subcutaneously at bedtime. Review of the Blood Glucose/Insulin	{D 358}		

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{D 358}	Continued From page 14 Administration Report provided for Resident #2 revealed: -There were blood glucose results beginning 12/02/21 through 12/14/21. -The blood glucose results ranged from 187 to 400, with the first documented blood glucose result of 317 on 12/02/21 at 7:00am. -The second and highest documented blood glucose result was 400 on 12/03/21 at 4:30pm. Review of the contracted pharmacy dispensing history for Resident #2 revealed a single entry for Lantus Insulin dispensed to the facility on 12/10/21. Telephone interview with the second former PCP for Resident #2 at 3:01pm on 12/15/21 revealed: -There were concerns that Resident #2's insulin was not administered as ordered. -Resident #2's insulin should have been administered as ordered to avoid hyperglycemia which could result in the resident experiencing diabetic ketoacidosis (a high level of blood acids which can lead to a diabetic comma and death). Refer to the interview with the Health and Wellness Director (HWD) on 12/15/21 at 11:13am. Refer to the telephone interview with the contracted pharmacy on 12/15/21 at 4:57pm. Refer to the interview with the Executive Director/Administrator (ED) on 12/15/21 at 11:29am. Refer to the second interview with the Health and Wellness Director on 12/15/21 at 2:40pm. Refer to the interview with the medication aide on	{D 358}		

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{D 358}	Continued From page 15 12/15/21 at 2:45pm. Refer to the interview with the second former PCP for Resident #2 on 12/15/21 at 3:01pm. Refer to the interview with the Resident Care Coordinator (RCC) on 12/15/21 at 3:31pm. Refer to the third interview with the HWD on 12/15/21 at 3:51pm. Refer to the second interview with the ED on 12/15/21 at 3:31pm. Refer to the interview with the first former PCP for Resident #2 on 12/15/21 at 4:30pm. c. Review of physician orders for Resident #2 revealed: -There was a physician's order on the current FL-2 dated 09/09/21 for Sertraline 50mg tablet (used to treat depression, panic attacks, and anxiety disorders) daily. -There were no subsequent physician orders discontinuing the Sertraline as ordered. -There was a Physician Order Review dated 11/04/21 by the second former PCP. -There was not a physician's order on the 11/04/21 physician order review for the Sertraline. Review of the October 2021, November 2021, and December 2021 eMARs for Resident #2 revealed there was no entry to the eMARs for Sertraline. Review of the contracted pharmacy dispensing history for Resident #2 revealed Sertraline 50mg tablet had not been dispensed to the facility. Telephone interview with the second former PCP	{D 358}		

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{D 358}	Continued From page 16 for Resident #2 at 3:01pm on 12/15/21 revealed there was no concern that Resident #2's Sertraline was not administered as ordered and staff had not reported any anxiety, agitation, or depression. Refer to the interview with the Health and Wellness Director (HWD) on 12/15/21 at 11:13am. Refer to the telephone interview with the contracted pharmacy on 12/15/21 at 4:57pm. Refer to the interview with the Executive Director/Administrator (ED) on 12/15/21 at 11:29am. Refer to the second interview with the Health and Wellness Director on 12/15/21 at 2:40pm. Refer to the interview with the medication aide on 12/15/21 at 2:45pm. Refer to the interview with the second former PCP for Resident #2 at 3:01pm on 12/15/21. Refer to the interview with the Resident Care Coordinator (RCC) on 12/15/21 at 3:31pm. Refer to the third interview with the HWD on 12/15/21 at 3:51pm. Refer to the second interview with the ED on 12/15/21 at 3:31pm. Refer to the interview with the first former PCP for Resident #2 on 12/15/21 at 4:30pm. d. Review of physician orders for Resident #2 revealed:	{D 358}		

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{D 358}	Continued From page 17 -There was a physician orders on the current FL-2 dated 09/09/21 for Ativan (used to treat anxiety and agitation) 0.5mg tablet two times a day. -There were no subsequent physician orders discontinuing the Ativan as ordered. -There was a Physician Order Review dated 11/04/21 by the second former PCP. -There were no orders on the 11/04/21 physician order review for the Ativan. Review of the October 2021, November 2021, and December 2021 eMARs for Resident #2 revealed: -There was no entry to the eMARs for Ativan. Review of the contracted pharmacy dispensing history for Resident #2 revealed Ativan 0.5mg tablet had not been dispensed to the facility. Telephone interview with the second former PCP for Resident #2 at 3:01pm on 12/15/21 revealed there was no concern that Resident #2's Ativan 0.5 mg tablet twice a day was not administered as ordered if she was not agitated or did not have any anxiety. Refer to the interview with the Health and Wellness Director (HWD) on 12/15/21 at 11:13am. Refer to the telephone interview with the contracted pharmacy on 12/15/21 at 4:57pm. Refer to the interview with the Executive Director/Administrator (ED) on 12/15/21 at 11:29am. Refer to the second interview with the Health and Wellness Director on 12/15/21 at 2:40pm.	{D 358}		

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{D 358}	Continued From page 18 Refer to the interview with the medication aide on 12/15/21 at 2:45pm. Refer to the interview with the second former PCP for Resident #2 on 12/15/21 at 3:01pm. Refer to the interview with the Resident Care Coordinator (RCC) on 12/15/21 at 3:31pm. Refer to the third interview with the HWD on 12/15/21 at 3:51pm. Refer to the second interview with the ED on 12/15/21 at 3:31pm. Refer to the interview with Resident #2's first former PCP on 12/15/21 at 4:30pm. e. Review of physician orders for Resident #2 revealed: -There was a physician's order on the current FL-2 dated 09/09/21 for Trazodone (used to treat anxiety and inability to sleep) 25mg tablet at bedtime. -There was no subsequent physician's order discontinuing the Trazodone as ordered. -There was a Physician Order Review dated 11/04/21 by the second former PCP. -There was not a physician's order on the 11/04/21 physician order review for the Trazodone. Review of the October 2021, November 2021, and December 2021 eMARs for Resident #2 revealed there were no entries to the eMARs for Trazodone. Review of the contracted pharmacy dispensing history for Resident #2 revealed Trazodone 25mg	{D 358}		

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{D 358}	Continued From page 19 tablet had not been dispensed to the facility. Telephone interview with the second former PCP for Resident #2 at 3:01pm on 12/15/21 revealed there were no concerns that Resident #2's Trazodone was not administered as ordered, and there was no harm to Resident #2. Refer to the interview with the Health and Wellness Director (HWD) on 12/15/21 at 11:13am. Refer to the telephone interview with the contracted pharmacy on 12/15/21 at 4:57pm. Refer to the interview with the Executive Director/Administrator (ED) on 12/15/21 at 11:29am. Refer to the second interview with the Health and Wellness Director on 12/15/21 at 2:40pm. Refer to the interview with the medication aide on 12/15/21 at 2:45pm. Refer to the interview with the second former PCP for Resident #2 on 12/15/21 at 3:01pm. Refer to the interview with the Resident Care Coordinator (RCC) on 12/15/21 at 3:31pm. Refer to the third interview with the HWD on 12/15/21 at 3:51pm. Refer to the second interview with the ED on 12/15/21 at 3:31pm. Refer to the interview with the first former PCP for Resident #2 on 12/15/21 at 4:30pm.	{D 358}		

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{D 358}	Continued From page 20 f. Review of physician orders for Resident #2 revealed: -There was a physician's order on the current FL-2 dated 09/09/21 for Melatonin (used as a sleep aid) 3mg tablet at bedtime. -There were no subsequent physician orders discontinuing the Melatonin. -There was a Physician Order Review dated 11/04/21 by a second former PCP. -There was not a physician's order on the 11/04/21 physician order review for the Melatonin. Review of the October 2021, November 2021, and December 2021 eMARs for Resident #2 revealed: -There were no entries to the eMARs for Melatonin. Review of the contracted pharmacy dispensing history for Resident #2 revealed Melatonin 3mg tablet had not been dispensed to the facility. Telephone interview with Resident #2's previous PCP at 3:01pm on 12/15/21 revealed: -There were no concerns that Resident #2's Melatonin was not administered as ordered. -There was no harm to the resident. Refer to the interview with the Health and Wellness Director (HWD) on 12/15/21 at 11:13am. Refer to the telephone interview with the contracted pharmacy on 12/15/21 at 4:57pm. Refer to the interview with the Executive Director/Administrator (ED) on 12/15/21 at 11:29am. Refer to the second interview with the Health and	{D 358}		

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{D 358}	Continued From page 21 Wellness Director on 12/15/21 at 2:40pm. Refer to the interview with the medication aide on 12/15/21 at 2:45pm. Refer to the interview with the second former PCP for Resident #2 on 12/15/21 at 3:01pm. Refer to the second interview with the Resident Care Coordinator (RCC) on 12/15/21 at 3:31pm. Refer to the third interview with the HWD on 12/15/21 at 3:51pm. Refer to the interview with the ED on 12/15/21 at 3:31pm. Refer to the interview with the first former PCP for Resident #2 on 12/15/21 at 4:30pm. g. Review of physician orders for Resident #2 revealed: -There was a physician's order on the current FL-2 dated 09/09/21 for Vitamin C (dietary supplement) 500mg tablet two times a day. -There were no subsequent physician orders discontinuing the Vitamin C. -There was a Physician Order Review dated 11/04/21 by the second former PCP. -There was not a physician's order on the 11/04/21 physician order review for the Vitamin C. Review of the October 2021, November 2021, and December 2021 eMARs for Resident #2 revealed there were no entries to the eMARs for the Vitamin C. Review of the contracted pharmacy dispensing history for Resident #2 revealed the Vitamin C 500mg tablet had not been dispensed to the	{D 358}		

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{D 358}	Continued From page 22	{D 358}		

facility.

Telephone interview with Resident #2's second former PCP at 3:01pm on 12/15/21 revealed:
-There was no concern that Resident #2's Vitamin C 500mg twice a day was not administered as ordered.
-She was not aware of what diagnosis would support continuing the medication.

Refer to the interview with the Health and Wellness Director (HWD) on 12/15/21 at 11:13am.

Refer to the telephone interview with the contracted pharmacy on 12/15/21 at 4:57pm.

Refer to the interview with the Executive Director/Administrator (ED) on 12/15/21 at 11:29am.

Refer to the second interview with the Health and Wellness Director on 12/15/21 at 2:40pm.

Refer to the interview with the medication aide on 12/15/21 at 2:45pm.

Refer to the interview with the second former PCP for Resident #2 on 12/15/21 at 3:01pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 12/15/21 at 3:31pm.

Refer to the third interview with the HWD on 12/15/21 at 3:51pm.

Refer to the second interview with the ED on 12/15/21 at 3:31pm.

Refer to the interview with the first former PCP for

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{D 358}	Continued From page 23 Resident #2 on 12/15/21 at 4:30pm. h. Review of physician orders for Resident #2 revealed: -There was a physician's order on the current FL-2 dated 09/09/21 for Pro-stat (dietary supplement) AWC 17- 100gm 30ml two times a day. -There were no subsequent physician orders discontinuing the Pro-stat. -There was a Physician Order Review dated 11/04/21 by the second former PCP. -There was not a physician's order on the 11/04/21 physician order review for the Pro-stat. Review of the October 2021, November 2021, and December 2021 eMARs for Resident #2 revealed there were no entries to the eMARs for the Pro-stat. Review of the contracted pharmacy dispensing history for Resident #2 revealed Pro-stat had not been dispensed to the facility. Telephone interview with the second former PCP for Resident #2 on 12/15/21 at 3:01pm revealed: -There was no concern that Resident #2's Pro-stat was not administered as ordered. -There was no harm to Resident #2. -If Resident #2 had been administered the Pro-stat, she (PCP) would have restarted the Pro-stat. Refer to the interview with the Health and Wellness Director (HWD) on 12/15/21 at 11:13am. Refer to the telephone interview with the contracted pharmacy on 12/15/21 at 4:57pm.	{D 358}		

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{D 358}	Continued From page 24 Refer to the interview with the Executive Director/Administrator (ED) on 12/15/21 at 11:29am. Refer to the second interview with the Health and Wellness Director on 12/15/21 at 2:40pm. Refer to the interview with the medication aide on 12/15/21 at 2:45pm. Refer to the interview with the second former PCP for Resident #2 on 12/15/21 at 3:01pm. Refer to the interview with the Resident Care Coordinator (RCC) on 12/15/21 at 3:31pm. Refer to the third interview with the HWD on 12/15/21 at 3:51pm. Refer to the second interview with the ED on 12/15/21 at 3:31pm. Refer to the interview with the first former PCP for Resident #2 on 12/15/21 at 4:30pm. _____ Interview with the Health and Wellness Director (HWD) on 12/15/21 at 11:13am revealed: -New physician orders for residents were received by the HWD or Resident Care Coordinator (RCC). -The HWD or RCC were responsible for faxing the physician orders to the contracted pharmacy provider after reviewing the orders. -The facility's contracted pharmacy input new orders to residents' electronic medication administration records (eMARs). -All department heads which included the Business Office Manager (BOM), the Executive Director (ED), the Resident Care Coordinator	{D 358}		

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{D 358}	Continued From page 25	{D 358}		

(RCC), and himself all had access to the facility's fax machine and could review a resident's interdisciplinary group (IDG) meeting notes.
-He would review the IDG meeting notes as soon as he removed them from the fax machine.
-If a resident had a new medication order documented on the IDG meeting notes then the RCC or himself would fax the IDG meeting notes to the facility's contracted pharmacy.
-The facility's contracted pharmacy would add the new medication to the resident's electronic medication administration record for the facility to approve.

Telephone interview with the contracted pharmacy on 12/15/21 at 4:57pm revealed:
-The pharmacy received only one page of the FL-2 dated 09/09/21 and a four-page physician order report (POR) dated 09/09/21.
-The pharmacy treated the FL-2 as the "official document, true orders".
-If there were differences in the orders on the FL-2 and POR, the pharmacy would not input on the eMARs those differences that were on the POR.

Second interview with the Health and Wellness Director on 12/15/21 at 2:40pm revealed:
-Medication orders for Resident #2 that were listed on page 2 and 3 of the 09/09/21 FL-2 were not faxed to the pharmacy when the resident was admitted to the facility on 09/09/21.
-He did not know why pages 2 and 3 of the 09/09/21 FL-2 were not faxed to the pharmacy.
-The second former PCP for Resident #2 signed the physician order review for the medications that had only been transcribed to the eMARs by the contracted pharmacy provider.
-On 12/15/21 he faxed to the current PCP the three pages of the original FL-2 and notified the

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{D 358}	Continued From page 26 PCP that physician orders for medications on pages 2 and 3 were never started. -He had not performed any review of resident orders since his employment at the facility. Interview with the medication aide on 12/15/21 at 2:45pm revealed: -She administered medications based on what was transcribed to the the eMARs. -She performed weekly medication cart audits to ensure medications listed on the eMARs were on hand and to reorder resident medications from the pharmacy. -The facility staff did not check physician chart orders against the eMARs or medication on hand. Interview with the ED on 12/15/21 at 11:29am revealed: -Upon admission, Resident #2's FL-2 would have gone through her first then she would have given the FL-2 to the RCC. -The RCC was responsible for sending the FL-2 to the facility's contracted pharmacy. Interview with Resident #2's second former PCP on 12/15/21 at 3:01pm revealed: -Resident #2 was transferred to her care in November 2021. -She had signed the physician order review dated 11/04/21 to provide a continuation of care knowing Resident #2 would be coming to her office for a face-to-face visit on 12/02/21. -Resident #2's first visit to her office was 12/02/21. -Her PCP group had stopped coming to the facility from October 2021 to November 2021 due to COVID-19 and other circumstances at her office. -She was not aware only the first page of Resident #2's FL-2 dated 09/09/21 was faxed to	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026068	A. BUILDING: _____ B. WING _____	R-C 12/15/2021

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{D 358}	Continued From page 27 the facility's contracted pharmacy and the other pages were not faxed to the facility's contracted pharmacy upon her admission to the facility on 09/10/21. -She expected the facility to administer medication as ordered or to call her if a medication clarification was necessary when a new resident was admitted to the facility. Interview with the RCC on 12/15/21 at 3:31pm revealed: -She had been the RCC at the facility for about 6 months. -Her responsibilities included assisting the HWD with the medication cart audits. -She had no role with resident admissions except to send resident's FL-2 to the facility's contracted pharmacy and the resident's pharmacy agreement. -The facility's process in place to ensure there were no PCP's orders that were missed was the HWD and the RCC checked behind each other. -After the resident's medication orders were faxed to the facility's contracted pharmacy, a staff member from the pharmacy entered them into the resident's eMAR. -The RCC/the HWD verified all the residents' medications listed on that FL-2 had been entered on the resident's eMAR. -Upon Resident #2's admission to the facility, she remembered sending the first page of her FL-2, her pharmacy agreement, 4 pages of a document titled, physician order review, which was signed and dated by a PCP. -She did not send the remainder of Resident #2's FL-2 because she was not aware there was more than 1 page. -When she received the FL-2 from the ED she thought the paperwork that followed the first page of Resident #2's FL-2 was other paperwork that	{D 358}		

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{D 358}	Continued From page 28 was unrelated to the FL-2. Third interview with the HWD on 12/15/21 at 3:51pm revealed: -He expected staff to follow the medication orders written by the PCP. -He expected staff to fax the medication orders to the facility's contracted pharmacy. -He expected staff to verify the medication orders were entered correctly into the facility's electronic medication administration record. Second interview with the ED on 12/15/21 at 3:31pm revealed: -Upon admission to the facility, Resident #2's FL-2 was given to the RCC who was new in her role. -She was not aware the last 2 pages of Resident #2's FL-2 were not faxed to the facility's contracted pharmacy by the RCC. -She was very concerned that Resident #2's diabetic medications were not being administered as ordered. -Resident #2 could have had a diabetic issue or had a serious fall due to her diabetic medications not being administered as ordered. -Resident #2 had a fall (the date was not provided) and she fractured her finger. -She expected staff to implement the new medication orders into the facility's electronic medication administration record, so the resident was administered their ordered medications in a timely manner. Interview with Resident #2's first former PCP on 12/15/21 at 4:30pm revealed: -He completed Resident #2's FL-2 prior to her transfer to the facility. -Once a resident was transferred to the new facility, there was a transition of care to the new	{D 358}		

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{D 358}	Continued From page 29 PCP. -Resident's orders including medication orders would be considered the new facility's responsibility to implement. -He expected medications to be administered as ordered. -He expected Resident #2's medication orders for Pro-stat, Vitamin C, Melatonin, Trazadone, Novolog insulin, and Lantus insulin to be administered as ordered. -Resident #2 was supposed to get her ordered medications and have her fingerstick blood sugars completed. -If Resident #2 was not administered her ordered medications, there could a bad outcome, for example, a hospitalization or death. The current PCP was not available for interview. Based on observations and record review, it was determined Resident #2 was not interviewable. _____ The facility failed to administer medications as ordered for 1 of 5 sampled residents (#2) including orders for 2 types of insulins for greater than 2 months resulting in documented blood sugars as high as 400. The facility's failure was detrimental to the health and welfare of the resident and constitutes an Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G. S. 131D-34 on 12/15/21 for this violation.	{D 358}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights	{D912}		

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{D912}	Continued From page 30 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 ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to health care. The findings are: 1. Based on observations, record review, and interviews, the facility failed to administer medications as ordered by a prescribing practitioner to 1 of 5 sampled residents (#2), including medications used for treatment in lowering blood sugars, anxiety and agitation, sleep disorders, and a dietary supplement. [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Unabated Type B Violation).] 2. Based on interviews and record reviews, the facility failed to ensure physician orders for accuchecks was implemented for 1 of 5 sampled residents (#2). [Refer to Tag 276, 10A NCAC 13F .0902(c) (3-4) Health Care (Type B Violation).]	{D912}		