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	HAL049010	A. BUILDING: _____ B. WING _____	11/29/2022

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D 000	Initial Comments The Adult Care Licensure Section conducted an Annual and Follow-up survey on November 28-29, 2022.	D 000		
D 259	10A NCAC 13F .0802(a) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) An adult care home shall assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within 30 days following admission according to Rule .0801 of this Section. The care plan is an individualized, written program of personal care for each resident. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure 1 of 5 sampled residents (#2) had a completed care plan within 30 days of admission. The findings are: Review of Resident #2's current FL2 dated 09/12/22 revealed: -Diagnoses included diabetes, neuropathic and muscle weakness. -Resident #2 was independent with all activities of daily living. Review of Resident #2's Resident Register revealed an admission date of 09/09/22. Review of Resident #2's licensed health professional support (LHPS) evaluation dated 10/03/22 revealed she received insulin via injection.	D 259		

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D 259	Continued From page 1 Review of Resident #2's record from 11/28/22 to 11/29/22 revealed there was no documentation of a completed care plan and one was not available prior to exit on 11/29/22. Interview with Resident #2 on 11/28/22 at 9:30am revealed she required assistance with bathing. Interview with the Resident Care Coordinator (RCC) on 11/29/22 at 11:45am revealed: -She was responsible for filling out the resident's care plans within the first 30 days of admission. -She had been very busy and did not complete Resident #2's care plan. -If resident's do not have a completed care plan, staff rely on information obtained from the resident register, FL2 and family. -A new resident's record will stay at the Nurse's station for 72 hours after admission so the resident's care needs can be documented. -Staff also gave verbal report on the resident's care needs at shift change. Interview with the Administrator on 11/29/22 at 4:00pm revealed: -The RCC was responsible for filling out care plans soon after admission. -She knew that the RCC had been very busy and was on vacation shortly after Resident #2 was admitted. -She was not aware that Resident #2 did not have a completed care plan. -The RCC was responsible for completing chart audits but she was not sure the last time one was completed.	D 259		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care	D 276		

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(c) The facility shall assure documentation of the following in the resident's record:
(3) written procedures, treatments or orders from a physician or other licensed health professional; and
(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure implementation of orders to hold two blood thinning medications and administer a laxative for 1 of 5 sampled residents (#1) prior to a colonoscopy.

The findings are:

Review of Resident #1's current FL2 dated 02/26/22 revealed:
-Diagnoses included Alzheimer's Disease, atrial flutter (abnormal heart rhythm), complete atrioventricular block (disruption of the electrical signal in the heart) and pacemaker.
-There was an order for aspirin 81mg daily.
-There was an order for warfarin (a blood thinning medication) 5mg daily.

Review of Resident #1's physician orders dated 09/28/22 revealed:
-There was an order for aspirin 81mg daily.
-There was an order for warfarin 5mg daily.

Interview with Resident #1 on 11/28/22 at 9:46am revealed he was scheduled to have a colonoscopy the next day (11/29/22).

a. Review of Resident #1's Gastrologist's visit note dated 10/05/22 revealed:
-Resident #1 was scheduled to have an

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endoscopy (a scope to examine the digestive tract) and a colonoscopy (a scope to examine the large intestines) on 11/29/22 at 11:00am.
-Resident #1's warfarin was to be stopped five days prior to the procedure on 11/24/22.

Review of Resident #1's Gastrologist's written orders dated 10/05/22 revealed:
-Resident #1's warfarin was to be held five days prior to the procedure, starting 11/24/22.
-The warfarin was to resume after the procedure.

Review of Resident #1's November 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for warfarin 5mg one tablet daily at 5:00pm.
-The warfarin was documented as administered from 11/01/22 to 11/27/22.

Refer to the telephone interview with a Pharmacist from the facility's contracted pharmacy on 11/29/22 at 11:37am.

Refer to the interview with a Medication Aide (MA) supervisor on 11/29/22 at 12:15pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 11/29/22 at 12:49pm

Refer to the telephone interview with Resident #1's Gastrologist on 11/29/22 at 1:12pm.

Refer to the interview with the Administrator on 11/29/22 at 4:00pm.

Attempted telephone interview with the transportation staff on 11/29/22 at 10:45am was unsuccessful.

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b. Review of Resident #1's Gastrologist's visit note dated 10/05/22 revealed:
-Resident #1 was scheduled to have an endoscopy and colonoscopy on 11/29/22 at 11:00am.
-Resident #1's aspirin was to be stopped two days prior to the procedure, on 11/27/22.

Review of Resident #1's Gastrologist's written orders dated 10/05/22 revealed:
-Resident #1's aspirin was to be held two days prior to the procedure, starting 11/27/22.
-The aspirin was to resume the day after the procedure, on 11/30/22.

Review of Resident #1's November 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for aspirin 81mg one tablet daily at 8:00am.
-The aspirin was documented as administered from 11/01/22 to 11/28/22.

Refer to the telephone interview with a Pharmacist from the facility's contracted pharmacy on 11/29/22 at 11:37am.

Refer to the interview with a MA supervisor on 11/29/22 at 12:15pm.

Refer to the interview with the RCC on 11/29/22 at 12:49pm

Refer to the telephone interview with Resident #1's Gastrologist on 11/29/22 at 1:12pm.

Refer to the interview with the Administrator on 11/29/22 at 4:00pm.

Attempted telephone interview with the

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transportation staff on 11/29/22 at 10:45am was unsuccessful.

c. Review of Resident #1's Gastrologist's visit note dated 10/05/22 revealed:
-Resident #1 was scheduled to have an endoscopy and colonoscopy on 11/29/22 at 11:00am.
-Resident #1's was to take two bisacodyl laxative tablets at bedtime on 11/27/22.

Review of Resident #1's electronically transmitted prescription dated 10/05/22 revealed Resident #1 was to take bisacodyl 5mg, two tablets at bedtime on 11/27/22.

Review of Resident #1's November 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for bisacodyl 5mg, two tablets at bedtime two nights before the procedure.
-There was no documentation the bisacodyl had been administered to Resident #1 on 11/27/22.

Interview with the RCC on 11/28/22 at 2:36pm revealed:
-The bisacodyl order was electronically sent to the pharmacy and the pharmacy placed the medication order on Resident #1's eMAR.
-She spoke with a representative from the facility's contracted pharmacy on 11/28/22 and it was determined the bisacodyl entry was not entered correctly on Resident #1's eMAR by the pharmacy.
-The pharmacy had incorrectly entered a "start time" of 6:00am and an "end time" of 12:00pm on 11/27/22 for the bisacodyl entry.
-The bisacodyl entry was discontinued prior to the bedtime medication pass on 11/27/22 and did not

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appear on the bedtime eMAR for the MA to administer the medication to Resident #1.

Interview with a Pharmacist from the facility's contracted pharmacy on 11/29/22 at 11:37am revealed:
-The pharmacy received an electronic prescription for Resident #1's bisacodyl 5mg, two tablets to be administered on 11/27/22 at bedtime.
-Bisacodyl 5mg, two tablets were dispensed to the facility on 11/23/22.
-The pharmacy incorrectly entered the start and stop times on the bisacodyl entry for Resident #1 and it never 'popped' on the eMAR for the medication aide (MA) to administer.
-The bisacodyl was prescribed to help cleanse the colon prior to Resident #1's colonoscopy.

Refer to the interview with a MA supervisor on 11/29/22 at 12:15pm.

Refer to the interview with the RCC on 11/29/22 at 12:49pm.

Refer to the interview with the Administrator on 11/29/22 at 4:00pm.

Attempted telephone interview with the transportation staff on 11/29/22 at 10:45am was unsuccessful.

_____

Telephone interview with a Pharmacist from the facility's contracted pharmacy on 11/29/22 at 11:37am revealed:
-The pharmacy was responsible for entering new orders onto the residents' electronic Medication Administration record (eMAR).
-All new orders placed on residents' eMARs had to be approved by facility staff after the orders

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were reviewed for accuracy.
-The facility could place a medication on hold in the eMAR system or they could fax the order to the pharmacy.

Interview with a Medication Aide (MA) supervisor on 11/29/22 at 12:15pm revealed:
-When a resident returned from a medical appointment via facility transportation, the transportation employee faxed new orders to the pharmacy or gave them to the Resident Care Coordinator (RCC) or the MA supervisor on duty.
-Medications placed on hold or suspended were to be faxed to the pharmacy.
-New orders placed by the pharmacy on the residents' electronic Medication Administration Record (eMAR) had to be approved by herself or the RCC.
-She reviewed and approved the bisacodyl entry for Resident #1 and failed to notice the time discrepancy on the order.

Interview with the Resident Care Coordinator (RCC) on 11/29/22 at 12:49pm revealed:
-When a resident returned from a medical appointment via facility transportation, the transportation employee typically faxed new orders to the pharmacy or gave them to her to fax to the pharmacy.
-She had not seen the gastroenterology paperwork and orders for Resident #1.
-The transportation employee should have given Resident #1's gastroenterology paperwork to the medication aide (MA) on duty if she was not able to fax it to the pharmacy.
-Medication holds or suspensions were typically faxed to the pharmacy, but she and the MA supervisor were able to place medication holds into the eMAR system.
-She and the MA supervisor were responsible for

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approving orders placed by pharmacy into the eMAR system.
-New orders in the eMAR system were to be checked for accuracy prior to approving them.

Telephone interview with Resident #1's Gastrologist on 11/29/22 at 1:12pm revealed:
-Resident #1 was to have a screening colonoscopy and an esophagogastroduodenoscopy (EGD) (a scope to examine the inside of the esophagus, stomach, and duodenum) on 11/29/22.
-She did not think an INR blood test (a test to measure time for blood to clot) was done at the GI clinic immediately prior to the procedure.
-She expected the facility to place Resident #1's warfarin and aspirin on hold as ordered and administer the bisacodyl as ordered.
-The warfarin and aspirin were placed on hold prior to the procedures for increased risk of bleeding if the resident were to need a polypectomy (removal of a polyp) or biopsy during the procedure.
-The colonoscopy and EGD were rescheduled for 01/30/23.

Interview with the Administrator on 11/29/22 at 4:00pm revealed:
-She expected all new orders and medication holds to be faxed to the pharmacy when received.
-The RCC or the MA supervisor were responsible to review and approve new orders placed on the eMAR by pharmacy.
-When a resident returned from a medical appointment via facility transportation, the transportation staff typically faxed new orders to the pharmacy.
-If the transportation staff was unable to fax any new orders to the pharmacy, the orders should have been given to the RCC or the MA

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D 276	Continued From page 9 supervisor. -She did not think there was a process in place for a second review of any paperwork returning with a resident from a medical appointment.	D 276		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to notify the county department of social services of any accident or incident requiring any medical treatment other than first aid for 1 of 5 sampled residents (#2). The findings are: Review of Resident #2's current FL2 dated 09/12/22 revealed diagnoses included diabetes, neuropathic and muscle weakness. Review of Resident #2's hospital discharge report dated 09/14/22 revealed: -Resident #2 presented to the Emergency Room (ER) on 09/11/22 after a fall, not feeling well for several days and feeling weak after standing for several days. -She was diagnosed with a urinary tract infection and bacteremia/sepsis (presence of bacteria in	D 451		

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the blood stream) and admitted to the hospital.
-Resident #2 was discharged from the hospital on 09/14/22.

Review of Resident #2's incident/accident reports on 11/28/22 revealed there was not a report generated for Resident #2's hospitalization from 09/11/22 to 09/14/22.

Interview with a medication aide (MA) on 11/29/22 at 12:15pm revealed:
-She was not working on 09/11/22 but heard Resident #2 was sent to the ER due to weakness.
-She did not hear anything about Resident #2 falling on 09/11/22.
-The Supervisor in Charge (SIC) was responsible for filling out an incident/accident report if a resident had a physical injury and was sent to the ER.
-An incident/accident report was not filled out if a resident was sent to the ER for an illness or something other than a physical injury.

Interview with the Administrative Assistant on 11/29/22 at 11:45am revealed:
-Resident #2 was sent to the ER on 09/11/22 due to being too weak to get out of bed.
-Resident #2 did not fall on 09/11/22.

Interview with the Medication Aide Supervisor (MA Supervisor) on 11/29/22 at 4:35pm revealed:
-The MA Supervisor was responsible for filling out accident/incident reports.
-Accident/incident reports were only filled out if a resident had a physical injury or physical altercation.
-The accident/incident report would be filled out after the event even if the resident did not leave the facility for medical care.
-The facility did not require an accident/incident

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D 451	Continued From page 11 report to be filled out if a resident went to the ER for feeling unwell. Interview with the Administrator on 11/29/22 at 4:00pm revealed: -Accident/incident reports were filled out by the MA Supervisor after a resident fell or sustained an injury that required treatment at the ER. -The facility did not fill out accident/incident reports when residents went to the ER for something other than a physical injury. -She was not aware that an accident/incident report should be filled out every time a resident was sent to the ER for medical treatment.	D 451		