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THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 and complaint investigation on January 11 and 12, 2023.	{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 observations, interviews and record reviews, the facility failed to ensure follow up with the primary care provider (PCP) for blood sugar levels greater than written parameters and a mammogram referral for 2 of 5 sampled residents (#2 and #3). The findings are: 1. Review of Resident #3's current FL-2 dated 11/18/22 revealed: -Diagnoses included hyperglycemia, diabetes mellitus, acute kidney disease, femoral vein deep vein thrombosis and neuropathy. -There were orders for finger stick blood sugar (FSBS) checks three times daily and sliding scale insulin (SSI) with direction to notify the primary care provider (PCP) for FSBS results greater than 550. Review of Resident #3's November 2022 electronic medication administration record (eMAR) revealed: -There was an entry for SSI three times daily and instructions to notify the PCP for FSBS results greater than 550. -On 11/21/22 at 5:30pm the FSBS result was 551	{D 273}		

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{D 273}	Continued From page 1 and there was no documentation the PCP was notified. -On 11/22/22 at 12:30pm the FSBS result was 551 and there was no documentation the PCP was notified. -On 11/23/22 at 8:30am the FSBS result was 571 and there was no documentation the PCP was notified. Review of Resident #3's December 2022 eMAR revealed: -There was an entry for SSI three times daily and instructions to notify the PCP for FSBS results greater than 550. -On 12/20/22 at 5:30pm the FSBS result was 555 and there was no documentation the PCP was notified. -On 12/27/22 at 12:30pm the FSBS result was 552 and there was no documentation the PCP was notified. Review of Resident #3's January 2023 eMAR revealed: -There was an entry for SSI three times daily and instructions to notify the PCP for FSBS results greater than 550. -On 01/04/23 at 12:30pm the FSBS result was 562 and there was no documentation the PCP was notified. Review of Resident #3's electronic progress notes and physician notification forms revealed there was no documentation the PCP was contacted for FSBS results greater than 550 on 11/21/22, 11/22/22, 11/23/22, 12/20/22, 12/27/22 and 01/04/23. Telephone interview with Resident #3's primary care provider (PCP) on 01/12/23 at 12:16pm revealed:	{D 273}		

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{D 273}	Continued From page 2 -She did not know of elevated blood sugars for Resident #3 off hand. -She would have to check the resident's record at the office for notification notes. -MAs could have faxed a notification or spoke to an on-call provider. -She was not able to access the physician's office records at the time of the call. Interview with the Resident Care Coordinator (RCC) on 01/12/23 at 4:05pm revealed the PCP was notified of Resident #3's high blood sugars when she came to the facility each week. Review of Resident #3's record revealed there was no documentation the PCP was notified for FSBS results greater than 550 on 11/21/22, 11/22/22, 11/23/22, 12/20/22, 12/27/22 and 01/04/23. Interview with the Administrator on 01/12/23 at 5:58pm revealed: -The PCP should have been notified by the MA and notification documented on the resident's eMAR and/or electronic progress note. -She was still learning the electronic record reporting and monitoring process for oversight on staff adherence to documenting contact with the PCP. Attempted telephone follow up interview with Resident #3's PCP on 01/13/22 at 9:56am was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable. 2. Review of Resident #2's current FL-2 dated 03/30/22 revealed:	{D 273}		

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{D 273}	Continued From page 3 -Diagnoses included hypothyroidism status post thyroidectomy, depression, hypernatremia, peripheral neuropathy, gait instability, gastroesophageal reflux disorder (GERD), osteoarthritis, multiple sclerosis, and hypertension. -The admission date to the facility was 03/04/21. Review of Resident #2's progress notes dated 07/14/22 revealed: -Resident #2 was being seen for complaint of breast pain. -The primary care provider ordered a mammogram for Resident #2. Review of Resident #2's record revealed there were no results for a mammogram. Interview with the Resident #2 on 01/11/23 at 9:35am revealed: -She had been requesting a mammogram since this past summer (2022). -She did not remember when her last mammogram was done. -She had been seeing her neurologist every 3 months before coming to the facility. -She had only seen her neurologist twice since her admission. Interview with Resident Care Coordinator (RCC) on 01/12/23 at 4:30pm revealed: -She was responsible for making appointments that the primary care provider (PCP) ordered. -She started at the facility on 08/17/22. -She only became aware of the mammogram order on 01/11/23 when it was requested by the survey team. -The previous RCC should have had the appointment made once the PCP orders were done.	{D 273}		

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{D 273}	Continued From page 4 -She was not aware of Resident #2 needing to see a neurologist. Interview with the Executive Director on 01/12/23 at 8:25am revealed: -The memory care coordinator (MCC) left in November 2022 on medical leave and thought she would be returning in December 2022. -The RCC had been covering her duties as well as some of the duties of the MCC since the MCC left. -The previous RCC would have been responsible for making the appointment for the mammogram. Telephone interview with the PCP on 01/12/23 at 12:37pm revealed: -She was not the PCP who had ordered the mammogram. -She reviewed her records for Resident #2 and found the mammogram order on 07/14/22. -She did not have any results if a mammogram had been done. -The last mammogram for which she had record was done in April 2021. -She expected when orders were given that the staff would follow through with the orders. Upon request on 01/11/23 at 12:56pm and again on 01/12/23 at 11:02am, mammogram results for Resident #2 were not provided by the facility for review..	{D 273}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments	{D 358}		

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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.

Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered by the primary care provider (PCP) for 3 of 5 sampled residents (#1, #3 and #4) including long acting insulins (#1 and #3), a narcotic pain reliever, an antihypertensive, an over the counter pain reliever, and vitamin supplement (#4).

The findings are:

1 Review of Resident #4's current FL-2 dated 01/05/23 revealed diagnoses included dementia, chronic ischemic heart disease, gait and mobility abnormalities, cerebral infarction, hypertension, osteoporosis and gastro-esophageal reflux disease.

a. Review of Resident #4's physician's order dated 12/22/22 revealed:
-An order to discontinue morphine three times daily (a narcotic pain medication used to treat moderate to severe pain).
-An order to continue as needed morphine.
-An order for morphine (100mg/5ml) 0.5ml daily at bedtime.

Observations of Resident #4's medications on

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{D 358}	Continued From page 6	{D 358}		

hand on 01/11/23 at 3:47pm revealed:
-There were 2 morphine 0.25ml prefilled syringes labeled for administration three times daily.
-There were 6 morphine 0.25ml prefilled syringed labeled for administration every 4 hours as needed for pain or shortness of breath.
-There were no morphine 0.5ml prefilled syringes.

Review of Resident #4's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for morphine 0.5ml daily at bedtime with a note that the medication needed a "script".
-The morphine was scheduled at 8:00pm and had a start date of 12/22/22.
-There was an "x" marked in the boxes for 12/23/22, 12/24/22, 12/25/22 and 12/26/22.
-There was documentation morphine 0.5ml was administered 12/27/22 through 12/31/22.
-There was an entry for morphine 0.25ml three times daily with a stop date of 12/22/22 and documentation doses were administered at 8:00am and 2:00pm.
-There was a second entry for morphine 0.25ml three times daily with a start date of 12/22/22 and stop date of 12/23/22.
-There was documentation morphine 0.25ml was administered at 8:00am, 2:00pm and 8:00pm on 12/23/22.
-The 8:00pm dose on 12/22/22 was documented as not administered because the medication was discontinued.
-There was an entry for morphine 0.25ml every 4 hours as needed for pain or shortness of breath.
-There was no documentation any doses were administered on 12/24/22, 12/25/22 or 12/26/22.
-There was an entry for morphine 15mg every 2 hours as needed for pain crisis or air hunger.
-There was no documentation any doses were

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{D 358}	Continued From page 7	{D 358}		

administered on 12/24/22, 12/25/22 or 12/26/22.
-There was no documentation Resident #4 received any form of morphine on 12/24/22, 12/25/22 and 12/26/22.

Interview with the Resident Care Coordinator (RCC) on 01/12/23 at 4:05pm revealed:
-Resident #4 had morphine available for administration from the previous order.
-MAs should have administered the morphine to Resident #4 on 12/24/22 through 12/26/22.
-She did not know why morphine was not administered on 12/24/22 through 12/26/22.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/13/23 at 10:08am revealed:
-The pharmacy received an electronic prescription order, which was a valid controlled substance (CS) prescription order, for morphine 0.25ml three times daily on 12/15/22 for Resident #4.
-The pharmacy dispensed 30 prefilled syringes of morphine 0.25ml for Resident #4.
-The pharmacy received the order to discontinue morphine 0.25ml three times daily and to start morphine 0.5ml daily at bedtime on 12/22/22 for Resident #4.
-The pharmacy did not receive a valid CS prescription order for morphine 0.5ml daily at bedtime for Resident #4 and did not dispense the new order.
-The pharmacy entered the order onto Resident #4's eMAR with a note that a valid CS prescription order was needed.
-Morphine was a narcotic pain medication used to treat moderate to severe pain.
-Missed doses could lead to not having pain controlled and withdrawal symptoms such as agitation, sweating and mental status changes if

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stopped abruptly.

Telephone interview with Resident #4's primary care provider (PCP) on 01/12/23 at 12:16pm revealed:
-She was not made aware of any delays in starting new or changed medication orders.
-She did not remember the details of changed or new orders for Resident #4.
-Some changes could have been made by the Hospice service.
-She was not at her computer to access her record of orders and notes for Resident #4.

Telephone interview with Resident #4's Hospice Nurse on 01/17/23 at 5:11pm revealed:
-She could not say why morphine was not administered 12/24/22 through 12/26/22 because she was not there for medication passes.
-She did not know the morphine order had been changed by the PCP.
-Resident #4 had pain mostly with transfers, bathing and at bedtime according to the staff.
-Hospice was supposed to manage medication orders.
-All new orders were supposed to be communicated to her by staff so she could enter them into the hospice system and send them to the pharmacy directly for clarity and billing purposes.
-CS orders sent directly to the pharmacy by hospice were on a valid CS prescription order.

Attempted telephone interview with a second shift medication aide (MA) on 01/12/23 at 3:29pm was unsuccessful.

b. Review of Resident #4's physician's orders dated 01/05/23 revealed and order for Ativan/Benadryl/Haldol/Reglan (ABHR)

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{D 358}	Continued From page 9 1/25/1/10mg gel topical to wrist daily as needed for agitation and before bathing (used to treat agitation and anxiety). Observations of Resident #4's medications on hand on 01/11/23 at 3:47pm revealed there was no ABHR gel for the resident. Review of Resident #4's January 2023 electronic medication administration record (eMAR) revealed there was an entry for ABHR gel 1ml daily as needed for agitation and before bathing with a start date of 01/05/23 and no doses documented as having been administered. Interview with a medication aide (MA) on 01/12/13 revealed the ABHR gel for Resident #4 had not arrived from the pharmacy yet. Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/13/23 at 10:08am revealed: -The pharmacy received the order for ABHR gel for Resident #4, but the order was not on a valid prescription order for a controlled substance (CS). -The pharmacy noted in the directions on the eMAR system that a CS prescription order was needed. -The pharmacy had not received a valid CS prescription order and therefore did not dispense ABHR gel for Resident #4. -There was no documentation of a call with staff regarding the ABHR gel. Telephone interview with Resident #4's primary care provider (PCP) on 01/12/23 at 12:16pm revealed she was not made aware of any delays in starting new or changed medication orders.	{D 358}		

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{D 358}	Continued From page 10 Telephone interview with Resident #4's Hospice Nurse on 01/17/23 at 5:11pm revealed: -ABHR gel was for agitation at bath time for Resident #4. She had recommended the medication but did not know it had been ordered by the PCP. -Hospice was supposed to manage medication orders. -All new orders were supposed to be communicated to her by staff so she could enter them into the hospice system and send them to the pharmacy directly for clarity and billing purposes. -CS orders sent directly to the pharmacy by hospice were on a valid CS prescription order. c. Review of Resident #4's current FL-2 dated 01/05/23 revealed there were orders to discontinue the following medications effective 01/06/23: acetaminophen 325mg 2 tablets three times daily (used to treat chronic pain), amlodipine 5mg daily (used for high blood pressure), clopidogrel 75mg daily (used to prevent blood clots), sertraline 25mg daily (used to treat depression), sertraline 50mg daily and vitamin D3 1000 units daily (used as a supplement). Observations of Resident #4's medications on hand on 01/11/23 at 3:47pm revealed: -There was a multidose pack (MDP) with Resident #4's name and a list of medications contained in the packages. -The list of medications included acetaminophen 325mg 2 tablets, amlodipine 5mg, clopidogrel 75mg, mirtazapine 7.5mg, sertraline 25mg, sertraline 50mg and vitamin D3 1000 units. -There was no morning MDP pack for 01/11/13 that included acetaminophen 325mg 2 tablets, amlodipine 5mg, clopidogrel 75mg, sertraline	{D 358}		

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{D 358}	Continued From page 11 25mg, sertraline 50mg and vitamin D3 1000 units. -There was no evening MDP pack for 01/11/13 that included acetaminophen 325mg 2 tablets. Review of Resident #4's January 2023 electronic medication administration record (eMAR) revealed: -There was an entry for acetaminophen 325mg two tablets three times daily at 8:00am, 2:00pm and 8:00pm with documentation doses were administered 01/01/23 through 01/11/23 at 2:00pm. -There was an entry for amlodipine 5mg daily at 8:00am with documentation doses were administered 01/01/23 through 01/11/23. -There was an entry for clopidogrel 75mg daily at 8:00am with documentation doses were administered 01/01/23 through 01/11/23. -There was an entry for sertraline 25mg daily at 8:00am with documentation doses were administered 01/01/23 through 01/11/23. -There was an entry for sertraline 50mg daily at 8:00am with documentation doses were administered 01/01/23 through 01/11/23. -There was an entry for vitamin D3 1000 units daily at 8:00am with documentation doses were administered 01/01/23 through 01/11/23. Interview with a medication aide (MA) on 01/12/23 at 11:48am revealed: -She had administered Resident #4's morning medications on 01/11/23 from the MDP. -She verified the medications in the MDP on the resident's eMAR prior to administering. -All the medications in the MDP were still active on the eMAR. -The Resident Care Coordinator (RCC) was responsible for processing new orders.	{D 358}		

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{D 358}	Continued From page 12 Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/13/23 at 10:08am revealed: -The pharmacy did not have a record of an FL-2 for Resident #4 with orders to discontinue amlodipine, acetaminophen, vitamin D, clopidogrel and sertraline. -Orders were primarily sent via fax or email by the Resident Care Coordinator (RCC). Telephone interview with Resident #4's primary care provider (PCP) on 01/12/23 at 12:16pm revealed: -She was not made aware of any delays in starting new or changed medication orders. -Amlodipine, acetaminophen, vitamin D, clopidogrel and sertraline were discontinued. -The medication was discontinued for quality of end of life. Telephone interview with Resident #4's Hospice Nurse on 01/17/23 at 5:11pm revealed: -She was not notified acetaminophen, amlodipine, clopidogrel, sertraline and vitamin D3 had been discontinued by the PCP. -She was supposed to be notified by staff of orders written by the PCP. Attempted telephone follow up interview with Resident #4's PCP on 01/13/22 at 9:56am was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable. Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on 01/13/23 at 10:08am.	{D 358}		

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{D 358}	Continued From page 13 Refer to interview with the Resident Care Coordinator (RCC) on 01/12/23 at 4:05pm. Refer to interview with the Administrator on 01/12/23 at 5:12pm. 2. Review of Resident #3's current FL-2 dated 11/18/22 revealed diagnoses included dementia, depression, hyperglycemia, acute kidney disease, hypothyroidism, neuropathy, thrombocytopenia, femoral vein deep vein thrombosis, diabetes mellitus, melanotic stools, hypertension and extremity swelling. a. Review of Resident #3's physician's order dated 12/08/22 revealed orders for Lantus 8 units every morning and Lantus 12 units daily at bedtime (a long-acting insulin used to regulate blood sugar levels). Review of Resident #3's physician's order dated 12/22/22 revealed orders to discontinue prior Lantus orders and start Lantus 12 units twice daily. Observation of Resident #3's medications on hand on 01/11/23 at 3:41pm revealed there was a Lantus injection pen with a label which included the resident's name and date opened (01/11/23). Review of Resident #3's December 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Lantus 8 units every morning with documentation doses were administered at 8:00am from 12/09/22 through 12/23/22. -There was an entry for Lantus 12 units daily at bedtime with documentation doses were administered at 8:00pm from 12/09/22 through	{D 358}		

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{D 358}	Continued From page 14 12/23/22. -There was an entry for Lantus 12 units twice daily with a start date of 12/23/22 and documentation doses were administered at 8:00am and 8:00pm from 12/27/22 through 12/31/22. -There was no documentation any dose of Lantus was administered on 12/24/22, 12/25/22 and 12/26/22. Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/13/23 at 10:08am revealed: -The pharmacy received the order for Lantus 12 units twice daily for Resident #3 on 12/22/22. -The order was entered into the pharmacy system, checked by a pharmacist and entered on to the eMAR on 12/22/22. -Lantus for Resident #3 was delivered to the facility on 12/23/22. -The pharmacy entered the new order for Lantus 12 units twice daily to start on 12/23/22 and all previous Lantus orders to stop at midnight on 12/22/22. -Not getting Lantus could cause high blood sugar levels. -High blood sugar levels have long term consequences affecting nerves, eyes and multiple other organ function. -Lantus was a long-acting insulin that mimicked normal basal levels of insulin in the body. Attempted telephone interview with a second shift medication aide (MA) on 01/12/23 at 3:29pm was unsuccessful. b. Review of Resident #3's current FL-2 dated 11/18/22 revealed an order for Floranex one packet twice daily (a probiotic supplement).	{D 358}		

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{D 358}	Continued From page 15 Review of Resident #3's physician's order dated 01/05/23 revealed an order to discontinue Floranex. Observation of Resident #3's medications on hand on 01/11/23 at 3:41pm revealed there was no Floranex for the resident. Review of Resident #3's November 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Floranex one packet twice daily with a start date of 11/16/22. -There was documentation 18 doses were administered from 8:00pm on 11/16/22 through 8:00pm on 11/25/22. -From 8:00am on 11/26/22 through 8:00am on 11/28/22 no doses were administered with a comment of waiting on pharmacy for the reason. -From 8:00pm on 11/28/22 through 8:00pm on 11/30/22, 5 doses were documented as administered. Review of Resident #3's December 2022 eMAR revealed: -There was an entry for Floranex one packet twice daily. -There was documentation 35 of 62 doses were administered from 12/01/22 through 12/31/22. -There was documentation 27 doses were not administered due to refusal (2), delayed (1), will notify PCP of med reorder (1), on hold (13), waiting on refill (1), waiting for pharmacy (8) and difficulty obtaining medication (1). -There was documentation on 12/29/22 that the PCP was notified of the difficulty obtaining the medication. Review of Resident #3's physician's orders revealed there were no orders to hold Floranex	{D 358}		

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{D 358}	Continued From page 16 between 12/01/22 and 12/31/22. Review of Resident #3's January 2023 eMAR revealed: -There was an entry for Floranex one packet twice daily with a stop date of 01/4/23. -There was documentation 4 of 9 doses were administered from 01/01/23 through 01/05/22. -There was documentation 5 doses were not administered due to waiting for pharmacy (4) and hospitalization (1). Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/13/23 at 10:08am revealed: -The pharmacy did not dispense Floranex for Resident #3. -The pharmacy received the order for Floranex 1 packet twice daily for Resident #3 on 11/15/22. -The pharmacy did not have any Floranex in stock and upon attempting to order it discovered it required prior authorization due to cost. -The Floranex was eventually profiled onto Resident #3's eMAR by the pharmacy billing department and discontinued on 01/04/23. Attempted telephone interview with Resident #3's PCP on 01/13/22 at 9:56am was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable. Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on 01/13/23 at 10:08am. Refer to interview with the Resident Care Coordinator (RCC) on 01/12/23 at 4:05pm.	{D 358}		

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{D 358}	Continued From page 17 Refer to interview with the Administrator on 01/12/23 at 5:12pm. 3. Review of Resident #1's current FL-2 dated 07/07/22 revealed diagnoses included lymphedema, hypertension and Type II diabetes. Review of Resident #1's physicians order dated 07/28/22 revealed there was an order for Levemir 12 units to be administered each evening at bedtime. (Levemir is an insulin medication used to control blood sugar in people with diabetes.) Review of Resident #1's record on 01/11/23 revealed there was no subsequent physician's order to resume Levemir 12 units. Review of Resident #1's physician's order dated 08/15/22 revealed an order to discontinue Levemir 12 units and start Levemir 14 units each evening at bedtime. Review of Resident #1's physician's order dated 11/09/22 revealed an order to discontinue Levemir (no dose indicated) and start Levemir 18 units. (There was no time of administration ordered.) Review of Resident #1's physician's order dated 11/17/22 revealed an order for to discontinue Levemir (no dose indicated) and start Levemir 20 units every evening at bedtime. Review of Resident #1's progress note dated 11/17/22 revealed -There was documentation Resident #1's primary care provider was contacted to clarify the order change to see if the am dose should be continued.	{D 358}		

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{D 358}	Continued From page 18 Review of Resident #1's electronic medication administration record (eMAR) for November 2022 revealed: -There was a computerized entry for Levemir 12 units to be injected at bedtime. -There was documentation Levemir 12 units was administered each evening at 8:00pm on 11/01/22 through 11/03 and from 11/10/22 through 11/17/22. -There was documentation Levemir 12 units was not administered 11/04/22 through 11/09/22 because the medication had been discontinued. -There was a computerized entry for Levemir 14 units to be injected at bedtime. -There was documentation Levemir 14 units was administered each evening at 8:00pm from 11/04/22 through 11/09/22. -There was a computerized entry for Levemir 18 units to be injected each day. -There was documentation Levemir 18 units was administered each day at 8:00am from 11/11/22 through 11/17/22 in addition to the Levemir 12 units at 8:00pm for a total of 7 days. Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/13/23 at 10:08am revealed -The pharmacy began reconciling medication orders for pending contract with the facility in August 2022 for the go live date on 10-03-22. -The Levemir order at the time of reconciliation for Resident #1 was discontinue Levemir 12 units and start Levemir 14 units each night at bedtime which was dated 08/11/22. -They never had an order for Levemir 12 units for Resident #1. Telephone interview with Resident #1's primary care provider (PCP) on 01/12/23 at 11:15am revealed:	{D 358}		

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{D 358}	Continued From page 19 -Levemir 12 units at bedtime was discontinued and 14 units was started in August 2022 for Resident #1 and should not be on the eMAR for administration. -Levemir was a long acting insulin and was not meant to be administered twice daily. -There was little change in Resident #1's bloodsugar readings in November, but she adjusted his insulin based on the values, so it was important he be administered the medication as prescribed to ensure his blood sugar was controlled. -She did not remember being contacted for clarification of any Levemir order, but contact could have been made with her office. Interview with the Resident Care Coordinator (RCC) on 01/12/23 at 4:05pm revealed: -Resident #1 was still receiving Levemir 12 units each evening at bedtime in October 2022. -She did not know how the order was continued after it was discontinued in August 2022. -She called Resident #1's PCP on 11/17/22 and spoke with her regarding clarification of the Levemir order. -The PCP gave her the correct order, but she could not remember what that order was, and she did not document the PCP's response. Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on 01/13/23 at 10:08am. Refer to interview with the Resident Care Coordinator (RCC) on 01/12/23 at 4:05pm. Refer to interview with the Administrator on 01/12/23 at 5:12pm. _____ Telephone interview with a pharmacist from the	{D 358}		

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{D 358}	Continued From page 20 facility's contracted pharmacy on 01/13/23 at 10:08am revealed: -The pharmacy entered orders into their system, a pharmacist reviewed the order and then entered the order onto the eMAR system. -Staff reviewed and approved the order on the eMAR. -Staff had the ability to enter, discontinue and modify orders directly on the eMAR. -Staff were not supposed to enter orders; the order entry system was intended to be pharmacy driven. Interview with the Resident Care Coordinator (RCC) on 01/12/23 at 4:05pm revealed: -The electronic medication administration record (eMAR) system caused the delay in starting medications. -Every time there was a medication refill the eMAR system reset the medication entry and required her to approve the medication for each refill for the medication to be active on the eMAR. -She was responsible for sending medication orders to the facility's contracted pharmacy. -The pharmacy processed the order and entered the medication on the eMAR for approval. -She was responsible for approving medication orders entered on the eMAR by the pharmacy. -If the medication was not entered on the eMAR in a timely manner she called the pharmacy to follow up. -Medication orders from 12/22/22 did not come through on the eMAR system for approval until 12/27/22. -The facility's contracted pharmacy was closed on 12/23/22 through 12/26/22. -She and MAs had the ability to enter orders on the eMAR system when the medication was in the facility and available for administration.	{D 358}		

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{D 358}	Continued From page 21 Interview with the Administrator on 01/12/23 at 5:12pm revealed: -The RCC was responsible for approving medication orders on the eMAR when the order was entered into the system by the pharmacy. -The RCC had the ability to make changes to the eMAR. -She expected medication orders to be accurate so medications could be administered as ordered. _____ The facility failed to administer medications as ordered by the primary care provider (PCP) for 3 of 5 sampled residents resulting in Resident #4, who was receiving hospice care, not receiving scheduled morphine for 3 days and Resident #3, who had diabetes mellitus, not receiving Lantus for 3 days which was detrimental to the health, safety and wellbeing of these residents and constitutes an Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/13/23 for this violation.	{D 358}		
{D 465}	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.	{D 465}		

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{D 465}	Continued From page 22 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the minimum number of staff were always present to meet the needs of residents in the special care unit (SCU), for 1 of 9 shifts sampled. The findings are: Review of the facility's license effective 01/01/23 revealed the facility was licensed for a capacity of 120 beds including 60 beds for the assisted living (AL) area and 60 beds for the SCU. Observation of the facility on 01/11/23 at 9:00am revealed: -The facility was a multi-level facility consisting of three floors (a ground floor, first and second floors). -The special care unit (SCU) was located on the first floor which was accessible by locked doors to the stairwell or through the elevator access which both required a keypad access to enter the first floor. -The facility's current SCU census on 01/11/23 was 21 residents. Review of the facility's resident census report, daily staff assignment sheet, and staff timecards dated 01/01/23 revealed: -One first shift out of 3 first shifts sampled was not staffed to regulation for 21 SCU residents. -The SCU census was 21 which required 21 aide hours on first and second shifts. -The first shift assignment had two PCAs assigned to the SCU. -Staff timecards had a total of 15 hours 30 minutes staff hours provided on SCU for first shift for a shortage of 5 hours and 30 minutes.	{D 465}		

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{D 465}	Continued From page 23 Interview with a PCA on 01/11/23 at 10:00am revealed there were usually enough staff on duty Monday through Friday; if there was a shortage, it was on the weekends. Interview with a medication aide on 01/11/23 at 4:30pm revealed: -The medication aides (MAs) worked 12 hour shifts 7:00am to 7:00pm and 7:00pm to 7:00am both weekdays and weekends. -The personal care aides (PCAs) worked 8-hour shifts Monday - Friday (7:00am-3:00pm 1st shift, 3:00pm-11:00pm 2nd shift and 11:00pm-7:00am 3rd shift). -The PCAs worked 12-hour shifts, 7:00am to 7:00pm and 7:00pm to 7:00am, on the weekends. -There were MAs and PCAs working from a sister facility to help cover the shifts. -There was not a Special Care Unit Coordinator for the facility that she knew about; she had only seen the Resident Care Coordinator. Interview with the Executive Director on 01/12/23 at 8:25am revealed: -She made the schedule and the daily assignment sheets. -She made sure they were running the right number of staff to cover the census of the residents. -The SCU staff based on the census now was 4 staff on 1st and 2nd shifts and 3 staff on third shift. -The assignment sheet would designate which floor/area the staff were assigned to work. -If staff called out, they would try and find coverage for their shift. -The staff on duty could work over to cover. -The staff who received the call out should let her know or if anyone had to leave early, they should let her know as well.	{D 465}		

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{D 465}	Continued From page 24 -The salaried staff, such as the Resident Care Coordinator or herself the ED, could work the floor as a staff member if needed.	{D 465}		