| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | HAL008034 | A. BUILDING: _____ B. WING _____ | R 01/05/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WINDSOR HOUSE | 336 SOUTH RHODES AVENUE WINDSOR, NC 27983 |

| (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 |
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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted a follow up survey on 01/04/23 to 01/05/23. | D 000 | Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law. | |
| D 344 | 10A NCAC 13F .1002(a) Medication Orders<br><br>10A NCAC 13F .1002 Medication Orders<br>(a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments:<br>(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;<br>(2) if orders are not clear or complete; or<br>(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.<br>The facility shall ensure that this verification or clarification is documented in the resident's record.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to ensure clarification of medication orders for 2 of 4 sampled residents (#1, #4) who were administered the wrong dose of a medication used to control high blood sugar (#1) and a medication used to control high blood pressure (#4).<br><br>The findings are:<br><br>1. Review of Resident #1's current FL-2 dated 12/09/22 revealed:<br>-Diagnoses included dementia, acute kidney injury, acute hyperglycemia, diabetes mellitus type 2, hypertension, and congestive heart failure.<br>-There was an order for Basaglar KwikPen | D 344 | Windsor House shall ensure contact with the resident's Provider for verification or clarification of orders for medications and treatments in the following situations: if orders for admission/ readmission are not dated and signed within 24 hours of admission/ readmission to the facility; if orders are not clear or complete; and if multiple admission forms are received upon admission/ readmission and the orders on the forms are not the same. The clarifications will be documented in the Resident's record.<br><br>Special Care Coordinator (SCC) contacted PCP for clarification of Resident #1 and #4 medication orders. 1/5/23<br><br>Area Clinical Director (ACD) in-serviced all Med Techson the 6 rights of medication administration, preventing medication errors, proper medication documentation, and appropriate order processing. 1/16/23<br><br>SCC will process all orders per policy, ensuring there is no delay in medication administration. SCC will be sure to clarify orders received that are not clear and complete. Once orders are processed per policy, they will be secured in the resident's medical record. New order information will be shared with the Medication Aides. 2/19/23<br><br>SCC will ensure that Med Techs know to notify the SCC/ Executive Director (ED) aware if unclear/ incomplete orders are received so that prompt attention and follow-up can occur. 2/19/23 | |



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: LaVonna A. Wallace — TITLE: Executive Director — (X6) DATE: February 13, 2023



Reviewed & Acknowledged
-Millan Diaz 02/14/23

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| D 344 | Continued From page 1<br><br>Insulin, inject 5 units every morning. (Basaglar is a long-acting insulin used to control high blood sugar).<br>-The level of care for Resident #1 was the Special Care Unit (SCU).<br><br>Review of Resident #1's Resident Register revealed an admission date of 10/10/22.<br><br>Observation of Resident #1's 8:00am medication pass on 01/04/23 revealed:<br>-The resident was administered Basaglar KwikPen Insulin, 5 units at 9:10am.<br>-The resident's fingerstick blood sugar (FSBS) level was 387.<br><br>Observation of Resident #1's medications on hand on 01/05/23 at 3:10pm revealed the label on the bag that the Basaglar KwikPen Insulin came in from the pharmacy, dated 11/16/22 and opened 12/09/22, had instructions to inject Basaglar KwikPen 20 units every morning.<br><br>Review of Resident #1's medication order dated 11/16/22 revealed an order for Basaglar KwikPen Insulin inject 20 units every morning.<br><br>Review of Resident #1's medication order dated 11/30/22 and electronically signed by the primary care provider (PCP) on 12/02/22 revealed:<br>-There was an order to discontinue Basaglar KwikPen Insulin, inject 20 units every morning.<br>-There was an order to start Basaglar KwikPen Insulin, inject 5 units every morning.<br><br>Review of Resident #1's signed physician order report dated 12/09/22 revealed an order for Basaglar KwikPen Insulin, inject 5 units every morning at 8:00am. | D 344 | SCC will ensure new medications from outside pharmacies have an accompanying order. If the order is not available with the medication, the SCC will call the pharmacy to request a copy of the prescription. SCC will ensure that prescriptions from outside pharmacies are faxed for pofile to the house pharmacy, and finally secured in the Resident's record.<br><br>SCC will ensure change of direction stickers are placed on medication packages that do not match the directions on the MAR, and that Med Techs are made aware so that documentation on the 24 hour communication log can occur.<br><br>SCC will monitor order processing system daily to ensure there are not medication orders awaiting clarification. If such are present, SCC will work to assist in expediting the process.<br><br>SCC will run EMAR compliance reports daily, and review for accuracy and compliance. The report will be discussed with the ED daily during management meeting for any needed follow-up.<br><br>Med Techs will complete weekly MAR to Cart audits per facility schedule to ensure adequate and accurate medications are on hand for Resident use. Completed cart audits will be submitted to the Lead SIC for review and needed follow-up.<br><br>SCC and Lead SIC will complete weekly cart audits for the overall QA of the medication cart to ensure the cart is stocked with appropriate and accurate medications. Any areas of concern will be corrected at the time of discovery with MD notification as needed. Completed cart audits by the SCC will be submitted to the ED for verification.<br><br>SCC will complete a minimum of two chart audits weekly to ensure all orders have been processed accurately. Completed chart audits will be submitted to the ED for verification. | 2/19/23<br><br>2/19/23<br><br>2/19/23<br><br>2/19/23<br><br>2/19/23<br><br>2/19/23 |

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| D 344 | Continued From page 2<br><br>Review of Resident #1's new prescription summary electronically signed by the PCP dated 12/09/22 at 4:40pm and faxed to the facility by pharmacy on 12/09/22 at 9:36pm revealed an order for Basaglar KwikPen Insulin inject 20 units every morning.<br><br>Review of Resident #1's December 2022 eMAR revealed:<br>-There was an entry for Basaglar KwikPen Insulin, inject 20 units every morning.<br>-There was documentation Basaglar Insulin, 20 units was administered at 8:00am from 12/01/22 to 12/02/22 and from 12/12/22 to 12/15/22 and discontinued on 12/16/22.<br>-There was no documentation that Basaglar Insulin was administered on 12/11/22.<br>-There was an entry for Basaglar KwikPen Insulin, inject 5 units every morning.<br>-There was documentation Basaglar, 5 units was administered at 8:00am from 12/03/22 to 12/10/22, and from 12/16/22 to 12/28/22 except on 12/17/22 that had the notation "had to clarify."<br>-There was an entry to check finger stick blood sugar (FSBS) levels three times a day with meals.<br>-There was documentation FSBS levels ranged from 93 to 498 at the 8:00am check from 12/01/22 to 12/28/22.<br>-There was documentation FSBS levels ranged from 134 to 548 with one reading too high to register on the glucometer at the 12:00pm check from 12/01/22 to 12/28/22.<br>-There was documentation FSBS levels ranged from 88 to 570 with one reading high to register on the glucometer at the 5:00pm check from 12/01/22 to 12/28/22.<br><br>Review of Resident #1's January 2022 eMAR revealed: | D 344 | | |

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| D 344 | Continued From page 3<br>-There was an entry for Basaglar KwikPen Insulin 5 units every morning.<br>-There was documentation Basaglar KwikPen Insulin 5 units was administered at the 8:00am medication pass on 01/04/23 and at 8:00am from 01/01/23 to 01/03/23.<br>-There was an entry to check FSBS three times a day with meals.<br>-There was documentation that FSBS levels ranged from 234 to 387 at the 8:00am check from 01/01/23 to 01/04/23.<br>-There was documentation that FSBS levels ranged from 287 to 353 at the 12:00pm check from 01/01/23 to 01/03/23.<br>-There was documentation that FSBS levels ranged from 319 to 389 with one reading too high for the glucometer to register at the 5:00pm check from 01/01/23 to 01/03/23.<br><br>Telephone interview with the facility's contracted pharmacy on 01/05/23 at 8:30 am revealed:<br>-An order dated 11/16/22 was received from Resident #1's PCP for Basaglar KwikPen 20 units every morning.<br>-An order change dated 12/02/22 was received from Resident #1's PCP for Basaglar KwikPen Insulin 5 units every morning.<br>-An order change dated 12/09/22 was received from Resident #1's PCP for Basaglar KwikPen Insulin 20 units every morning and was updated in the pharmacy system and submitted to the facility for approval.<br>-The pharmacy did not receive any notification from the facility that the Basaglar KwikPen Insulin 20 units every morning was not approved.<br>-Basaglar KwikPen Insulin Inject 20 units was dispensed for Resident #1 on 12/10/22.<br>-She did not know why the electronic medication administration record (eMAR) at the facility showed an entry for Basaglar 5 units every | D 344 | | |

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| D 344 | Continued From page 4<br>morning for Resident #1 after 12/10/22.<br>-The current medication order for Resident #1 was Basaglar KwikPen Insulin 20 units every morning.<br><br>Review of Resident #1's FSBS log from 11/14/22 to 12/14/22 revealed documentation of FSBS readings ranged from 93 to 597, with 6 readings too high for the glucometer to register.<br><br>Review of The American Diabetes Association (ADA) recommendations for individuals with a diagnosis of diabetes revealed:<br>-There was a recommendation for target blood sugar level of 80-130 before meals.<br>-There was a recommendation for target blood sugar level of 180 or less 1-2 hours after beginning a meal.<br>-High blood sugars should be treated as soon as they are detected.<br>-If left untreated, high blood sugar can lead to the risk of nerve damage, eye damage, heart disease, kidney disease and ketoacidosis (diabetic coma) which is a life threatening condition.<br><br>Interview with the medication aide (MA) on 01/05/23 at 3:00pm revealed:<br>-The Memory Care Coordinator (MCC) was responsible for sending medication orders and any clarification request to the pharmacy or provider.<br>-She administered Resident #1's Basaglar 5 units based on the eMAR.<br><br>Interview with the MCC on 01/05/22 at 9:20am revealed:<br>-She was responsible for submitting medication orders to the pharmacy to be entered into the pharmacy system and dispensed to the facility. | D 344 | | |

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| D 344 | Continued From page 5<br>-When the pharmacy entered medication orders into the pharmacy system and sent them to the facility, she was responsible for reviewing and approving the facility eMAR for accuracy.<br>-Medication cart audits were usually done weekly by the Lead MA and consisted of comparing the label on the medication to the eMAR for accuracy.<br>-She was responsible for ensuring medication cart audits were done.<br>-When medications were delivered by pharmacy to the facility weekly, the MAs received and signed for the medications.<br>-The labels on the medications were compared to the eMAR before placing them in the medication cart.<br>-She was responsible for ensuring medications received from pharmacy were checked against the eMAR before placing them in the medication cart.<br>-She was not familiar with the new prescription order dated 12/09/22 for Resident #1 for Basaglar KwikPen 20 units every morning.<br>-She was not aware or notified by the MAs of any discrepancy regarding Resident #1's Basaglar medication order until now.<br><br>Interview with the Administrator on 01/05/23 at 4:10 am revealed:<br>-She expected medication orders to be reviewed by the MCC for accuracy on the eMAR.<br>-She expected medication cart audits to be conducted weekly to compare medication labels with the eMAR for accuracy.<br>-The Lead MA usually conducted the medication cart audits.<br>-She expected the MCC to ensure medication audits were done and any discrepancies clarified and corrected immediately. | D 344 | | |

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| D 344 | Continued From page 6<br><br>Telephone interview with Resident #1's primary care provider (PCP) on 01/05/23 at 11:25am revealed:<br>-She was notified by the facility on 11/30/22 that Resident #1's FSBS reading was 529.<br>-She mistakenly keyed in an order for Basaglar 5 units every morning on 11/30/22.<br>-The intent was to change the current order from Basaglar 20 units to Basaglar 25 units to manage Resident #1's high blood sugar level.<br>-She did not receive any request for clarification from the facility regarding the order on 11/30/22 or 12/09/22.<br>-She expected the facility to notify her if there was a medication order discrepancy.<br>-She discovered the error on 12/09/22 and submitted a new prescription for Resident #1 to the facility for Basaglar 20 units every morning, which was the original order since she had increased Resident #1's other insulin (Novolog) on 12/09/22.<br>-The resident should be receiving Basaglar 20 units every morning since 12/09/22.<br><br>2. Review of Resident #4's current FL-2 dated 01/07/22 revealed:<br>-Diagnoses included dementia, altered mental status, major neurocognitive disorder, chronic subdural hematoma, hypertension, diabetes, and hyperlipidemia.<br>-The resident's current level of care was the Special Care Unit (SCU).<br><br>Review of Resident #4's Resident Register revealed an admission date of 12/28/21.<br><br>Review of Resident #4's physician order report dated 11/28/22 revealed there was an order for Amlodipine Besylate 10mg, 1 tablet daily at 9:00am. (Amlodipine is a medication used to treat | D 344 | | |

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| D 344 | Continued From page 7<br>high blood pressure (HBP)).<br><br>Review of Resident #4's physician visit report dated 11/28/22 and signed as received by the Memory Care Coordinator (MCC) revealed an order to increase Amlodipine to 10mg.<br><br>Observation of Resident #4's 9:00am medication pass on 01/04/23 revealed Amlodipine 5mg, 1 tablet was administered at 9:41am.<br><br>Observation of Resident #4's medication label on the bottle on 01/04/23 at 3:00pm revealed Amlodipine Besylate 5mg, 1 tablet daily.<br><br>Review of Resident #4's Emergency Room (ER) visit report dated 12/31/22 revealed a blood pressure (BP) reading of 193/105.<br><br>Review of Resident #4's facility vitals report from 11/01/22 to 01/05/23 revealed a BP of 168/92 on 01/02/23.<br><br>Review of the American Heart Association guidelines regarding blood pressure revealed:<br>-A normal BP was 120/80 ( the top number called the systolic was less than 120 and the bottom number called the diastolic was less than 80).<br>-Elevated blood pressure was when the systolic was between 120-129 and diastolic was less than 80.<br>-High blood pressure (hypertension )stage 1 was when the systolic was between 130-139 and diastolic was between 80-89.<br>-High Blood pressure (Hypertension) Stage 2 was when the systolic was 140 or higher or the diastolic 90 or higher.<br>-Hypertensive Crisis (consult your PCP immediately) was when the systolic was higher than 180 and/or diastolic greater than 120. | D 344 | | |

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| D 344 | Continued From page 8<br>-High Blood pressure could lead to the risk of a stroke, vision loss, heart attack/failure, and kidney disease/failure.<br><br>Review of Resident #4's November 2022 electronic medication record (eMAR) revealed:<br>-There was an entry for Amlodipine 10mg 1 tablet to be administered at 9:00am.<br>-There was documentation that Amlodipine 10mg, 1 tablet was administered at 9:00am from 11/02/22 to 11/04/22, from 11/06/22 to 11/07/22, from 11/09/22 to 11/10/22, from 11/13/22 to 11/16/22 from 11/18/22 to 11/20/22, 11/23/22 and 11/25/22.<br>There was documentation that Amlodipine 10mg, 1 tablet was not administered at 9:00am on 11/01/22 because of a doctors appointment, was not administered due to refusals on 11/05/22, 11/08/22, 11/11/22, 11/12/22, 11/17/22, 11/21/22, 11/22/22, 11/24/22 and from 11/26/22 to 11/28/22.<br><br>Review of Resident #4's December 2022 eMAR revealed:<br>-There was an entry for Amlodipine 10mg, 1 tablet daily.<br>-There was documentation that Amlodipine 10mg, 1 tablet was administered from 12//01/22 to 12/04/22, from 12/07/22 to 12/09/22 , 12/12/22, 12/14/22, 12/15/22, 12/20/22, 12/22/22, 12/23,22 12/25/22, and 12/28/22.<br>-There was documentation that Amlodipine 10mg, 1 tablet was not administered at 9:00am due to refusals on 12/05/22, 12/06/22, 12/11/22, 12/13/22, 12/16/22, 12/17/22, 12/18/22 , 12/19/22, 12/21/22, 12/24/22, 12/26/22 and 12/27/22 and being on hold on 12/10/22.<br><br>Review of Resident #4's January 2023 eMAR revealed:<br>-There was an entry for Amlodipine 10mg, 1 | D 344 | | |

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| D 344 | Continued From page 9<br>tablet daily.<br>-There was documentation Amlodipine 10mg, 1 tablet was administered at the 9:00am on 01/01/23, 01/03/23, and 01/04/23.<br>-There was documentation Amlodipine 10mg, 1 tablet was not administered at 9:00am on 01/02/23 due to refusal.<br><br>Interview with Resident #4's family member on 01/05/23 at 1:30pm revealed:<br>-She was aware Resident #4's Amlodipine had been changed from 5mg daily to 10mg daily on 11/28/22 when she accompanied him to his primary care provider (PCP).<br>-The order change was sent to the facility's contracted pharmacy, but Resident #4's primary care provider (PCP) forgot to send the updated prescription to the resident's private pharmacy who dispensed the resident's medications.<br>-She would contact the resident's PCP and pharmacy and bring the medication to the facility today.<br><br>Interview with the medication aide (MA) on 01/04/23 at 3:00pm revealed: -The entry on Resident #4's eMAR was Amlodipine 10mg.<br>-She did not notice Resident #4's medication bottle had Amlodipine 5mg on the label and contained 5mg tablets.<br>-She thought she administered Amlodipine 10mg and checked off on the eMAR.<br><br>Interview with the Memory Care Coordinator (MCC) on 01/05/23 at 9:20am revealed:<br>-She was aware Resident #4's Amlodipine had been changed from 5mg to 10mg.<br>-Resident #4 had his own private PCP and pharmacy.<br>-The resident's family member was responsible for ensuring medication orders were submitted to | D 344 | | |

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| D 344 | Continued From page 10<br>the resident's private pharmacy for dispensing.<br>-The facility would send medication orders for Resident #4 to the facility's contracted pharmacy to be entered into the system for the facility eMAR.<br>-The resident's pharmacy would send Resident #4's medication through the mail to the resident's family member.<br>-The resident's family member would bring Resident #4's medications to the facility.<br>-The medications received from the family member would be checked by the facility for accuracy against the eMAR.<br>-She did not know why the discrepancy on the label of the bottle compared to the eMAR regarding dose was not caught.<br><br>Interview with the Administrator on 01/05/23 at 4:10pm revealed:<br>-She expected the MCC to ensure medication cart audits were conducted weekly and the label on the medication to be compared to the eMAR for accuracy.<br>-She expected the MCC to coordinate with Resident #4's family member to ensure medications were clarified and accurate.<br><br>Attempted telephone interview with Resident #4's primary care provider (PCP) on 01/05/23 at 10:00am was unsuccessful. | D 344 | | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>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: | D 358 | Windsor House shall ensure that the preparation and administration of medications and treatments by staff are according to MD orders, which are kept in the Resident's record; according to the facility's policies and procedures; and rule .1004(a).<br><br>ACD inserviced Med Techs on the 6 rights of medication administration, preventing medication errors, proper medication | 1/16/23 |

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| D 358 | Continued From page 11<br><br>(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.<br><br>This Rule is not met as evidenced by:<br>UNABATED TYPE B VIOLATION<br><br>Based on observations, record reviews, and interviews the facility failed to administer medications as ordered during the medication pass for 2 of 4 residents (#1, #4) including a medication used for blood sugar control (#1), a medication used to treat high blood pressure, and a medication used to treat constipation and to lower ammonia level due to severe liver disease (#4).<br><br>The findings are:<br><br>The medication error rate was 10% as evidenced by the observation of 3 errors out of 30 opportunities during the medication pass on 01/04/23.<br><br>1. Review of Resident #1's current FL-2 dated 12/09/22 revealed:<br>-Diagnoses included dementia, acute kidney injury, acute hyperglycemia, diabetes mellitus type 2, hypertension, and congestive heart failure.<br>-There was an order for Basaglar KwikPen Insulin, inject 5 units every morning. (Basaglar is a long-acting insulin used to control high blood sugar).<br>-The level of care for Resident #1 was the Special Care Unit (SCU).<br><br>Review of Resident #1's Resident Register revealed an admission date of 10/10/22. | D 358 | documentation, and appropriate order processing.<br><br>Med Techs will complete daily MAR to Cart audits per facility schedule. Completed Cart audits will be reviewed daily by the Lead SIC for any needed follow-up.<br><br>SCC will ensure change of direction stickers are placed on medication packages that do not match the directions on the MAR, and that Med Techs are made aware so that documentation on the 24 Hour communication log can occur.<br><br>SCC will pull EMAR compliance report daily to review for compliance and accuracy with giving medications per MD orders.This will be reviewed with the ED during daily management meeting. MD will be notified as needed when not already done by the med techs to maintain compliance. | 2/19/23<br><br>2/19/23<br><br>2/19/23 |

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| D 358 | Continued From page 12<br><br>Observation of Resident #1's 8:00am medication pass on 01/04/23 revealed:<br>-The resident was administered Basaglar KwikPen Insulin, 5 units at 9:10am.<br>-The resident's fingerstick blood sugar (FSBS) level was 387.<br><br>Observation of Resident #1's medications on hand on 01/05/23 at 3:10pm revealed the label on the bag that the Basaglar KwikPen Insulin came in from pharmacy, dated 11/16/22 and opened on 12/09/22, had instructions to inject Basaglar KwikPen Insulin 20 units every morning.<br><br>Review of Resident #1's medication order dated 11/16/22 revealed an order for Basaglar KwikPen Insulin inject 20 units every morning.<br><br>Review of Resident #1's medication order dated 11/30/22 and electronically signed by the primary care provider (PCP) on 12/02/22 at 6:53am revealed:<br>-There was an order to discontinue Basaglar KwikPen Insulin, inject 20 units every morning.<br>-There was an order to start Basaglar KwikPen Insulin, inject 5 units every morning.<br><br>Review of Resident #1's signed physician order report dated 12/09/22 revealed an order for Basaglar KwikPen Insulin, inject 5 units every morning at 8:00am.<br><br>Review of Resident #1's new prescription summary electronically signed by the PCP dated 12/09/22 at 4:40pm and faxed to the facility on 12/09/22 at 9:36pm from the pharmacy revealed an order for Basaglar KwikPen Inject 20 units every morning.<br><br>Telephone interview with the facility's contracted | D 358 | | |

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| D 358 | Continued From page 13<br>pharmacy on 01/05/23 at 8:30 am revealed:<br>-An order dated 11/16/22 was received from Resident #1's PCP for Basaglar KwikPen Insulin 20 units every morning.<br>-An order change dated 12/02/22 was received from Resident #1's PCP for Basaglar KwikPen Insulin, 5 units every morning.<br>-An order change dated 12/09/22 was received from Resident #1's PCP for Basaglar KwikPen Insulin, 20 units every morning and was updated in the pharmacy system and submitted to the facility for approval.<br>-The pharmacy did not receive any communication from the facility that the order for Basaglar 20 units every morning dated 12/09/22 was not approved.<br>-The order for Basaglar KwikPen Insulin inject 20 units was dispensed for Resident #1 on 12/10/22.<br>-She did not know why the electronic medication administration record (eMAR) at the facility showed an entry for Basaglar KwikPen Insulin 5 units every morning for Resident #1 after the 12/10/22 date.<br>-The current medication order for Resident #1 was Basaglar KwikPen Insulin 20 units every morning.<br><br>Review of Resident #1's December 2022 eMAR revealed:<br>-There was an entry for Basaglar KwikPen Insulin, inject 20 units every morning.<br>-There was documentation Basaglar Insulin, 20 units was administered at 8:00am from 12/01/22 to 12/02/22 and from 12/12/22 to 12/15/22 and discontinued on 12/16/22.<br>-There was no documentation that Basaglar Insulin was administered on 12/11/22.<br>-There was an entry for Basaglar KwikPen Insulin, inject 5 units every morning.<br>-There was documentation Basaglar, 5 units was | D 358 | | |

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| D 358 | Continued From page 14<br>administered at 8:00am from 12/03/22 to 12/10/22, and from 12/16/22 to 12/28/22 except on 12/17/22 that had the notation "had to clarify."<br>-There was an entry to check finger stick blood sugar (FSBS) levels three times a day with meals.<br>-There was documentation FSBS levels ranged from 93 to 498 at the 8:00am check from 12/01/22 to 12/28/22.<br>-There was documentation FSBS levels ranged from 134 to 548 with one reading too high to register on the glucometer at the 12:00pm check from 12/01/22 to 12/28/22.<br>-There was documentation FSBS levels ranged from 86 to 570 with one reading too high to register on the glucometer at the 5:00pm check from 12/01/22 to 12/28/22.<br><br>Review of Resident #1's January 2022 eMAR revealed:<br>-There was an entry for Basaglar KwikPen Insulin 5 units every morning.<br>-There was documentation Basaglar KwikPen Insulin 5 units was administered at the 8:00am medication pass on 01/04/23 and at 8:00am from 01/01/23 to 01/03/23.<br>-There was an entry to check FSBS three times a day with meals.<br>-There was documentation that FSBS levels ranged from 234 to 387 at the 8:00am check from 01/01/23 to 01/04/23.<br>-There was documentation that FSBS levels ranged from 287 to 353 at the 12:00pm check from 01/01/23 to 01/03/23.<br>-There was documentation that FSBS levels ranged from 319 to 389 with one reading too high for the glucometer to register at the 5:00pm check from 01/01/23 to 01/03/23.<br><br>Review of Resident #1's FSBS log from 11/14/22 | D 358 | | |

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| D 358 | Continued From page 15<br>to 12/14/22 revealed documentation of FSBS readings ranged from 93 to 597, with 6 readings too high for the glucometer to register.<br><br>Review of The American Diabetes Association (ADA) recommendations for individuals with a diagnosis of diabetes revealed:<br>-There was a recommendation for target blood sugar level of 80-130 before meals.<br>-There was a recommendation for target blood sugar level of 180 or less 1-2 hours after beginning a meal.<br>-High blood sugar levels should be treated as soon as they are detected.<br>-If left untreated, high blood sugar can lead to nerve damage, vision loss, heart attack, kidney failure and ketoacidosis (diabetic coma) which is a life threatening condition.<br><br>Interview with the medication aide (MA) on 01/05/23 at 3:00pm revealed:<br>-The Memory Care Coordinator (MCC) was responsible for sending medication orders and any clarification request to the pharmacy or provider.<br>-She administered Resident #1's Basaglar 5 units based on the instructions on the eMAR.<br><br>Interview with the MCC on 01/05/22 at 9:20am revealed:<br>-She was responsible for submitting medication orders to the pharmacy to be entered into the pharmacy system and dispensed to the facility.<br>-When the pharmacy entered medication orders into the pharmacy system and send them to the facility, she was responsible for reviewing and approving the facility eMAR for accuracy.<br>-Medication cart audits were usually done weekly by the Lead MA and consisted of comparing the label on the medication to the eMAR for | D 358 | | |

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| D 358 | Continued From page 16<br>accuracy.<br>-She was responsible for ensuring medication cart audits were done.<br>-When medications were delivered by pharmacy to the facility weekly, the MAs received and signed for the medications.<br>-The labels on the medications were compared to the eMAR before placing them in the medication cart.<br>-She was responsible for ensuring medications received from pharmacy were checked against the eMAR before placing them in the medication cart.<br>-She was not aware of the Basaglar insulin order for 20 units dated 12/09/22.<br>-She was not aware or notified by the MAs of any discrepancy regarding Resident #1's Basaglar medication order until now.<br><br>Interview with the Administrator on 01/05/23 at 4:10 am revealed:<br>-She expected medication orders to be reviewed by the MCC for accuracy on the eMAR.<br>-She expected medication cart audits to be conducted weekly to compare medication labels with the eMAR for accuracy.<br>-The Lead MA usually conducted the medication cart audits.<br>-She expected the MCC to ensure medication audits were done and any discrepancies corrected and clarified immediately.<br><br>Telephone interview with Resident #1's PCP on 01/05/23 at 11:25am revealed:<br>-She was notified on 11/30/22 by the facility that Resident #1's FSBS reading was 529.<br>-She mistakenly keyed in an order for Basaglar KwikPen Insulin 5 units every morning on 11/30/22.<br>-The intent was to change the current order from | D 358 | | |

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| D 358 | Continued From page 17<br><br>Basaglar 20 units to Basaglar 25 units to manage Resident #1's high blood sugar level.<br>-She had left out the 2 when she keyed in the medication order in the electronic system.<br>-She did not receive any request for clarification from the facility regarding the order on 11/30/22.<br>-She expected to receive a request for clarification form the facility regarding any any discrepancies related to the medication orders on 11/30/22 and 12/09/22.<br>-She discovered the error on 12/09/22 and submitted a new prescription for Resident #1 to the facility and pharmacy for Basaglar 20 units every morning, which was the original dose since she had increased Resident #1's Novolog.<br>-The resident should be receiving Basaglar 20 units every morning since 12/09/22.<br><br>2. Resident #4's current FL-2 dated 01/07/22 revealed:<br>-Diagnoses included dementia, altered mental status, major neurocognitive disorder, chronic subdural hematoma, hypertension, diabetes, and hyperlipidemia.<br>-The resident's current level of care was the Special Care Unit (SCU).<br><br>Review of Resident #4's Resident Register revealed an admission date of 12/28/21.<br><br>a. Review of Resident #4's physician order report dated 11/28/22 revealed there was an order for Lactulose solution, 100gram/15ml with the instructions to administer 30ml daily at 9:00am for elevated ammonia level. (Lactulose is a medication used to treat constipation, and to lower ammonia level due to severe liver disease).<br><br>Observation of Resident #4's 9:00am medication pass on 01/04/23 revealed: | D 358 | | |

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| D 358 | Continued From page 18<br>-The resident was administered Lactulose 15ml at 9:41am.<br>-The resident was very confused and required a considerable amount of coaching and time from the MA to get him to take his medication.<br><br>Review of Resident #4's January 2022 electronic medication record (eMAR) revealed:<br>-There was an entry for Lactulose solution, 10gram/15ml with the instructions to administer 30ml daily at 9:00am for elevated ammonia.<br>-There was documentation that Lactulose 30ml was administered on 01/04/23 at the 9:00am medication pass.<br><br>Interview with the medication aide (MA) on 01/04/23 at 3:00pm revealed:<br>-She looked at the first part of th medication order on the eMAR that had 10gram/15ml and thought the Lactulose dose for Resident #4 was 15ml.<br>-She did not notice the instructions on the eMAR to admininister 30ml.<br><br>Interview with the Memory Care Coordinator (MCC) on 01/05/22 at 9:20am revealed she expected Resident #4's Lactulose to be administered based on the instructions on the eMAR.<br><br>Interview with the Administrator on 01/05/23 at 4:10pm revealed:<br>-She expected Resident #4's Lactulose to be administered according to the instructions on the eMAR.<br>-The MA needed additional training on the administration of medications.<br><br>Attempted telephone interview with Resident #4's primary care provider (PCP) on 01/05/22 at 10:00am was unsuccessful. | D 358 | | |

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| D 358 | Continued From page 19<br><br>b. Review of Resident #4's physician order report dated 11/28/22 revealed there was an order for Amlodipine Besylate 10mg, 1 tablet daily at 9:00am. (Amlodipine is a medication used to treat high blood pressure).<br><br>Review of Resident #4's physician visit report dated 11/28/22 and signed as received by the Memory Care Coordinator (MCC) revealed an order to increase Amlodipine to 10mg.<br><br>Observation of Resident #4's 9:00am medication pass on 01/04/23 revealed Amlodipine 5mg, 1 tablet was administered at 9:41am.<br><br>Observation of Resident #4's medication label on the bottle on 01/04/23 at 3:00pm revealed Amlodipine Besylate 5mg, 1 tablet daily.<br><br>Review of Resident #4's Emergency Room (ER) visit report dated 12/31/22 revealed a blood pressure (BP) reading of 193/105.<br><br>Review of Resident #4's facility vitals report from 11/01/22 to 01/05/23 revealed a BP of 168/92 on 01/02/23.<br><br>Review of the American Heart Association guidelines regarding blood pressure revealed:<br>-A normal BP reading was 120/80 (the top number called the systolic number was less than 120 and the bottom number called the diastolic number was less than 80).<br>-Elevated blood pressure was when the systolic was between 120-129 and diastolic was less than 80.<br>-High blood pressure (hypertension) stage 1 was when the systolic was between 130-139 and diastolic was between 80-89. | D 358 | | |

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| D 358 | Continued From page 20<br><br>-High blood pressure (hypertension) stage 2 was when the systolic was 140 or higher or the diastolic 90 or higher.<br>-Hypertensive Crisis (consult your PCP immediately) was when the systolic was higher than 180 and/or diastolic greater than 120.<br>-High Blood pressure could cause a stroke, vision loss, heart attack/failure and kidney disease/failure.<br><br>Review of Resident #4's January 2022 electronic medication record (eMAR) revealed:<br>-There was an entry for Amlodipine 10mg, 1 tablet daily.<br>-There was documentation Amlodipine 10 mg, 1 tablet was administered at the 9:00am medication pass.<br><br>Interview with Resident #4's family member on 01/05/23 at 1:30pm revealed:<br>-She was aware Resident #4's Amlodipine had been changed from 5mg daily to 10mg daily on 11/28/22 when she accompanied him to his primary care provider (PCP).<br>-The order change was sent to the facility's contracted pharmacy, but Resident #4's primary care provider (PCP) forgot to send the updated prescription to the resident's private pharmacy who dispensed the resident's medications.<br>-She did not know the facility could not administer 2 of the 5mg tablets in the medication bottle to Resident #4 without an order.<br>-She would contact the resident's PCP and pharmacy and bring the medication to the facility today.<br><br>Interview with the medication aide (MA) on 01/04/23 at 3:00pm revealed:<br>-The entry on Resident #4's eMAR was Amlodipine 10mg. | D 358 | | |

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| D 358 | Continued From page 21<br>-She did not notice Resident #4's medication bottle had Amlodipine 5mg on the label and contained 5mg tablets.<br>-She thought she administered Amlodipine 10mg.<br><br>Interview with the Memory Care Coordinator (MCC) on 01/05/23 at 9:20am revealed:<br>-She was aware Resident #4's Amlodipine had been changed from 5mg to 10mg.<br>-Resident #4 had his own private PCP and pharmacy.<br>-The resident's family member was responsible for ensuring medication orders were submitted to the resident's private pharmacy for dispensing.<br>-The facility would send medication orders for Resident #4 to the facility's contracted pharmacy to be entered into the system for the facility eMAR.<br>-The resident's private pharmacy would send Resident #4's medication through the mail to the resident's family member.<br>-The resident's family member would bring Resident #4's medications to the facility.<br>-The received medications from pharmacy would be checked by the MAs for accuracy against the eMAR.<br>-She did not know why the discrepancy on the label of the bottle compared to the eMAR regarding the dose was not caught.<br><br>Interview with the Administrator on 01/05/23 at 4:10pm revealed:<br>-She expected the MCC to ensure medication cart audits were conducted weekly and the label on the medication to be compared to the eMAR for accuracy.<br>-She expected the MCC to coordinate Resident #4's medication with the family member to ensure medication orders were accurate. | D 358 | | |

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| | HAL008034 | A. BUILDING: _____ B. WING _____ | R 01/05/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WINDSOR HOUSE | 336 SOUTH RHODES AVENUE WINDSOR, NC 27983 |

| (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 358 | Continued From page 22<br><br>Attempted telephone interview with Resident #4's primary care provider (PCP) on 01/05/22 at 10:00am was unsuccessful.<br><br>The facility failed to ensure the administration of medications as prescribed by the primary care provider (PCP) for 2 of 4 sampled residents (#1, #4), including a medication used to control high blood sugar levels for a resident with uncontrolled fingerstick high blood sugar (FSBS) readings as high as 597 and 9 readings too high to register on the glucometer that could lead to nerve damage, vision loss, heart attack, kidney failure, coma or death (#1), a medication used to treat high blood pressure for a resident with high blood pressure readings of 193/105 while hospitalized on 12/31/22 and 168/92 on 01/02/23 that could result in a stroke, vision loss, heart attack/failure and kidney disease/failure (#4), and a medication used to treat constipation and to lower ammonia level due to severe liver disease who had documented aggressive and confused behaviors (#4). This failure was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/05/23 for this violation. | D 358 | | |