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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow up survey on May 17 and 18, 2022.	{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: FOLLOW UP TO TYPE A2 VIOLATION Based on these findings, the previous Type A2 Violation was not abated. Based on observations, interviews and record reviews, the facility failed to notify the primary care provider (PCP) for 2 of 5 sampled residents (#1 and #2) for complaints of increased shortness of breath and heart palpitations in addition to the resident not receiving a cardiac medication for 7 days (#2) and for repeated refusals of medications for diabetes, pain, and electrolyte imbalances (#1). The findings are: 1. Review of Resident #2's current FL-2 dated 05/04/22 revealed diagnoses included dementia, atrial fibrillation with rapid ventricular response, hypertension, chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). Review of Resident #2's emergency department (ED) report dated 04/30/22 revealed: -The resident presented to the ED with mild	{D 273}		

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respiratory distress, tachypnea (increase respirations), wheezing, and found to be in atrial fibrillation (rapid but incomplete contractions of the upper chambers of the heart) with rapid ventricular response (lower chambers of the heart).
-The ED work up was consistent with CHF, probably high output failure (not enough blood to meet the body's need despite the volume pumped from the heart) from the resident's rapid heart rate.

Review of Resident #2's hospital cardiology consult note dated 04/30/22 revealed:
-The resident's initial heart rate was in the 140s.
-He had not received his Diltiazem for 3-4 days. (Diltiazem is used to treat atrial fibrillation and high blood pressure.)
-The resident was given 2 intravenous doses of Diltiazem before restarting oral doses.

Review of Resident #2's hospital discharge summary dated 05/04/22 revealed:
-The resident presented to the ED on 04/30/22 complaining of heart palpitations and had run out of his Diltiazem 2 days prior to admission to the hospital.
-He complained of shortness of breath and was found to have a heart rate of 150 on admission.
-He was also in CHF with an ejection fraction of 26% (measurement of blood pumped from the heart) on nuclear stress test (measures the hearts ability to respond to stress) and 40% on echocardiogram (ultrasound of the heart). (According to the American Heart Association normal ejection fraction is 50-75%.)

Interview with Resident #2 on 05/18/22 at 12:15pm revealed:
-For several days before he went to the hospital

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(04/30/22), he was having difficulty breathing that was increasingly noticeable to him.
-He told the staff and they offered to send him to the hospital, but he wanted to wait and see.
-He knew that pain medications with derivatives of morphine helped to regulate breathing because he had experienced caring for a family member on hospice.
-He knew his pain medication would help him to relax and breathe easier.
-Then his breathing got so bad he had to go to the hospital the night of 04/29/22.
-If he had known he was not getting the Diltiazem for his heart, he would have gone immediately to the hospital.

Interview with Resident #2 on 05/17/22 at 9:53am revealed:
-He was still recovering because he had multiple chronic health conditions including CHF, a heart valve problem, lupus and osteoarthritis.
-He found out from the emergency medical technicians (EMTs) that he was not getting his heart medication.

a. Review of Resident #2's physician order request dated 04/28/22 at 6:05am revealed:
-A medication aide (MA) documented the resident was complaining of heart palpitations through the night.
-The resident stated his morning medications usually helped him.
-He had been experiencing the heart palpitations a couple of nights in a row.
-He also had anxiety.
-The resident's primary care provider (PCP) signed the notification on 05/04/22.

Review of Resident #2's physician order request dated 04/30/22 at 1:35am revealed:

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-A MA documented the resident requested to go to the ED for heart palpitations, trouble breathing and stomach pain.
-The resident's PCP signed the notification on 05/04/22.

Review of Resident #2's April 2022 electronic progress notes revealed:
-On 04/29/22 at 10:46pm, a MA documented the resident was complaining of shortness of breath and chest discomfort.
-The resident refused to be sent to the hospital and reported feeling better later in the evening on 04/29/22.
-On 04/30/22 at 1:08am, a MA documented the resident was sent to the ED for heart palpitations.
-There was no documentation of Resident #2 reporting shortness of breath prior to 04/29/22.
-There was no documentation the resident's PCP and/or family member was called.

Telephone interview with a MA on 05/18/22 at 10:52am revealed:
-She was working the evening shift on 04/29/22 when Resident #2 complained of chest discomfort and difficulty breathing.
-He did not want to go to the emergency room because he thought if he took his pain medication, he would feel better.
-She checked on him before the end of her shift and he said he was alright.
-She notified the Resident Care Coordinator (RCC) by text message and was instructed to document a progress note.
-She did not contact the resident's primary care provider (PCP).

Telephone interview with a second MA on 05/18/22 at 3:20pm revealed:
-Resident #2 had looked "real anxious" toward

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the end of her shift (11:00pm to 7:00am) 2-3 times the week of 04/25/22.
-The resident told her he was having heart palpitations but said it would go away when he took his morning medications.
-She checked his vital signs on the night of 04/28/22 and 04/30/22 but she was not sure she documented the vital signs.
-She faxed a physician's notification sheet to the resident's PCP and called the RCC early in the morning before she left at 7:00am on 04/28/22.
-Notifying the PCP and RCC should have been documented in her progress note.
-The night of 04/29/22 into 04/30/22 he "just did not look good" so she sent him to the hospital.

Interview with the RCC on 05/18/22 at 12:04pm revealed:
-Staff reported to her Resident #2's complaints of anxiety, difficulty breathing, heart palpitations and chest discomfort on 04/28/22 and 04/29/22 the same day.
-She checked with the resident, and he said he did not want to go to the hospital.
-She verbally notified his PCP but did not document the contact with the PCP in a progress note.
-She did not remember the date she reported to the PCP.

Review of Resident #2's physical therapist (PT) visit note dated 04/28/22 revealed:
-The resident was experiencing shortness of breath and increased arythmias over the past 3 days especially at night.
-He was experiencing increased shortness of breath and fatigue when walking.
-He was having meals in his room due to low endurance and a feeling of passing out.
-He had notified staff immediately when he felt

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changes in his condition.

Review of Resident #2's PT visit note dated 04/29/22 at 3:50pm revealed:
-The resident was having increased shortness of breath that on 04/29/22.
-He required frequent rest periods during therapy due to shortness of breath and rapid increase in heart rate.
-His heart rate increased to 137 to 144 beats per minute and his blood oxygen saturation level (O2 sat) decreased to 82%.
-She reported the heart rate, O2 sat and shortness of breath to the RCC and MA on duty.

Second interview with the RCC on 05/18/22 at 6:00pm revealed:
-She did not know about the PT visit notes dated 04/28/22 and 04/29/22.
-She had not seen the notes before today (05/18/22).
-The PT did not talk to her about Resident #2's symptoms during his therapy on 04/29/22.
-She did not know the resident was having issues with his breathing and chest discomfort several days before he went to the hospital.

Interview with the Administrator on 05/18/22 at 6:10pm revealed:
-He remembered seeing Resident #2 working with the PT on 04/29/22.
-Neither the PT nor staff made him aware of the resident's complaints of difficulty breathing and chest discomfort.
-The MA and/or the RCC should have notified him.

Telephone interview with Resident #1's PCP on 05/18/22 at 11:35am revealed:
-She knew Resident #2 had issues with anxiety

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but did not know he was having palpitations.
-Palpitations were not knew for him, he had a history of palpitations.
-Staff may have contacted her on-call office but they did not call her regarding Resident #2 having chest discomfort, anxiety, palpitations and difficulty breathing on 04/28/22 and 04/29/22.

Interview with the Administrator on 05/18/22 at 12:48pm revealed:
-He was aware of Resident #2's complaints on 04/28/22 documented by staff.
-Normally staff notified the RCC and the RCC then let him know.
-He was made aware of the resident's complaints documented by staff on 04/29/22; he thought staff reported to him the next morning (04/30/22).
-Complaints of difficulty breathing, chest discomfort and palpitations should have been reported to the PCP and documented in a progress note by the MA.

b. Review of Resident #2's previous FL-2 dated 03/09/22 revealed an order for Diltiazem extended release (ER) 240mg daily. (Diltiazem is used to treat atrial fibrillation and high blood pressure.)

Review of Resident #2's April 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Diltiazem ER 240mg daily at 8:00am.
-There was documentation Diltiazem was administered from 04/01/22 through 04/22/22 and on 04/26/22.
-Doses of Diltiazem on 04/23/22, 04/24/22, 04/25/22, 04/27/22, 04/28/22 and 04/29/22 were documented on hold.
-On 04/30/22 the Diltiazem was not administered

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{D 273}	Continued From page 7 because the resident was hospitalized. Interview with a medication aide (MA) on 05/18/22 at 10:44am revealed: -She did not remember why Resident #2's Diltiazem was held when she administered his morning medications on 04/23/22 and 04/24/22. -She did not want to document the medication was refused when it was not available from the pharmacy, so she documented the medication was on hold when a medication was not in the building. -When a medication was placed on hold, she contacted the pharmacy. -She was sure she called the pharmacy about Resident #2's Diltiazem but she did not remember what was said. -There could have been an issue with the order. -She usually contacted the pharmacy, documented a progress note and reported to the RCC when a medication was not available. -The RCC usually contacted the resident's primary care provider (PCP). -She did not see where she documented a progress note on the resident's electronic record for 04/23/22 or 04/24/22. Review of Resident #2's April 2022 electronic progress notes revealed: -There were entries on 04/05/22 at 8:47am, 04/12/22 at 9:16am, and 04/26/22 at 2:25pm that cart audits had been completed. -There was no documentation the resident was low or out of Diltiazem as a result of the audit. -There was no documentation the pharmacy and/or the resident's PCP were notified about Diltiazem. Telephone interview with Resident #1's PCP on 05/18/22 at 11:35am revealed:	{D 273}		

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{D 273}	Continued From page 8 -She knew the resident needed refill orders for his Diltiazem, but she did not know he was out of the medication from 04/23/22 to 04/29/22 until he went to the hospital (04/30/22). -Resident #2 took Diltiazem for atrial fibrillation and not taking the Diltiazem could increase his heart rate. -She did not think missing 7 days of Diltiazem caused the resident to go to the hospital. -He went to the hospital for CHF and the rapid atrial fibrillation was a result of the CHF. Interview with the RCC on 05/18/22 at 12:04pm revealed: -The MAs did not let her know Resident #2 was out of Diltiazem, she found out while the resident was hospitalized. -She notified his PCP that he was out of the Diltiazem when he returned from the hospital (05/04/22). -If medications were not received in the facility within 2 days, the MAs were supposed to notify her and she contacted the pharmacy and resident's PCP. -If a medication was not included in the multidose pack (MDP), the MA notified the pharmacy that day and if the medication was not received within 1 day, the MA was supposed to notify her. Interview with the Administrator on 05/18/22 at 12:48pm revealed: -He became aware Resident #2 was out of Diltiazem the day before the resident returned from the hospital (05/03/22). -MAs were expected to call the pharmacy and notify the PCP if a resident's medications ran out. -MAs were supposed to document the contact with the pharmacy and the PCP in the progress notes.	{D 273}		

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2. Review of Resident #1's current FL-2 dated 03/17/22 revealed:
-Diagnoses included Type 2 diabetes and neuropathy.
-Ordered medications included pioglitazone 45 mg once a day, cyclobenzaprine 5 mg at bedtime, and sodium chloride 1 gm twice a day (pioglitazone was used to control diabetes, cyclobenzaprine was used for pain control, and sodium chloride was used for electrolytes).

Review of Resident #1's March 2022 Medication Administration Record (eMAR) revealed:
-An entry for pioglitazone 45 mg once a day was documented as refused by Resident #1 on 03/20, 03/21, 03/22, 03/23, 03/24, 03/25, 03/26, 03/27, 03/28, 03/29, 03/30, and 03/31.
-An entry for cyclobenzaprine 5 mg at bedtime was refused by Resident #1 on 03/22, 03/23, 03/24, 03/25, 03/26, 03/27, 03/28, 03/29, 03/30, and 03/31.
-An entry for sodium chloride 1 gm twice a day was documented as refused by Resident #1 on 03/20, 03/21, 03/22, 03/23, 03/24, 03/25, 03/26, 03/27, 03/28, 03/29, 03/30, and 03/31.

Review of Resident #1's April 2022 eMAR revealed:
-An entry for pioglitazone 45 mg once a day was documented as refused by Resident #1 on 04/01, 04/02, 04/03, 04/04, 04/05, 04/06, and 04/07.
-An entry for cyclobenzaprine 5 mg at bedtime was refused by Resident #1 on 04/01, 04/02, and 04/03.
-An entry for sodium chloride 1 gm twice a day was documented as refused by Resident #1 on 04/01, 04/02, 04/03, and 04/04.

Review of Resident #1's March-May 2022 progress notes did not reveal any documentation

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about notifying the physician of Resident #1's refusals.

Interview with a medication aide (MA) on 05/18/22 at 2:54pm revealed:
-Resident #1 does not usually refuse her medications.
-The physician should have been notified of Resident #1's refusals after the third consecutive refusal.
-She had not notified the physician of the refusals.
-Physician notification of refusals should be documented in the progress notes.
-She could not find any documentation that the physician had been notified of Resident #1's refusals.
-She did not know why the physician had not been notified.

Interview with a second MA on 05/18/22 at 3:08pm revealed:
-The physician should have been notified of refusals if the resident refused medications for 3 consecutive days.
-The physician notification should have been documented in the progress notes.

Interview with Resident #1 on 05/18/22 at 3:35pm revealed she did not remember refusing those medications.

Interview with Resident #1's primary care provider (PCP) on 05/18/22 at 4:35pm revealed:
-She was not aware Resident #1 had refused her medications.
-Resident #1 had difficulty controlling her blood sugar levels and needed the pioglitazone for her diabetes.
-Resident #1 used the cyclobenzaprine for pain

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{D 273}	Continued From page 11 control and she was evaluating the resident's pain levels for possibly discontinuing the medication. -Resident #1 needed the sodium chloride as a supplement and that without it, Resident #1 could have increased confusion and muscle spasms. Interview with the Resident Care Coordinator (RCC) on 05/18/22 at 5:54pm revealed: -She was not aware of Resident #1's medication refusals. -There were no progress notes that the PCP had been notified. -The PCP should be notified after the third time a resident had refused their medication. Interview with the Administrator on 05/18/22 at 5:57pm revealed the MAs should notify the RCC and the PCP when a resident refused their medications. _____ The facility failed to notify the primary care provider for changes in condition and medications not being available for administration for Resident #2. The facility's failure resulted in hospitalization for 4 days treatment of heart failure following a 2 day delay in notifying the PCP of increased shortness of breath and heart palpitations coinciding with 7 days without a medication to treat heart dysrhythmias (Diltiazem) for which the PCP was not notified. This failure resulted in substantial risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/18/22 for this violation.	{D 273}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration	{D 358}		

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{D 358}	Continued From page 12 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered by the prescribing practitioner for 4 of 5 sampled residents (#1, #2, #3 and #5) including medications for cardiac arythmias (#2), medication for diabetes (#1), a medication for chest pain (#5); and medications for depression and hypertension, an antiviral medication and a supplement (#3). The findings are: 1. Review of Resident #2's current FL-2 dated 05/04/22 revealed: -Diagnoses included dementia, atrial fibrillation with rapid ventricular response, hypertension, chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). -An order for Diltiazem extended release (ER) 240mg daily. (Diltiazem is used to atrial fibrillation and high blood pressure.) Review of Resident #2's previous FL-2 dated 03/09/22 revealed and order for Diltiazem ER 240mg daily.	{D 358}		

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{D 358}	Continued From page 13	{D 358}		

Interview with Resident #2 on 05/17/22 at 9:53am revealed:
-He ran out of a medication for his heart for 4 days.
-A "real bad thing happened," he went to the hospital for a week.
-He was still recovering because he had multiple chronic health conditions including CHF, a heart valve problem, lupus and osteoarthritis.
-He found out from the emergency medical technicians (EMTs) that he was not getting his heart medication.

Review of Resident #2's hospital cardiology consult note dated 04/30/22 revealed:
-The resident's initial heart rate was in the 140s.
-He had not received his Diltiazem for 3-4 days.
-The resident was given 2 intravenous doses of Diltiazem before restarting oral doses.

Review of Resident #2's hospital discharge summary dated 05/04/22 revealed:
-The resident presented to the ED on 04/30/22 complaining of heart palpitations and had run out of his Diltiazem 2 days prior to admission to the hospital.
-He complained of shortness of breath and was found to have a heart rate of 150 on admission.
-He was also in CHF with an ejection fraction of 26% (measurement of blood pumped from the heart) on nuclear stress test (measures the hearts ability to respond to stress) and 40% on echocardiogram (ultrasound of the heart). (According to the American Heart Association normal ejection fraction is 50-75%.)

Review of Resident #2's March 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Diltiazem ER 240mg daily

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{D 358}	Continued From page 14 at 8:00am starting 03/15/22. -There was documentation Diltiazem was administered from 03/16/22 through 03/31/22. -There were no missed or refused doses of Diltiazem documented. Review of Resident #2's April 2022 eMAR revealed: -There was an entry for Diltiazem ER 240mg daily at 8:00am. -There was documentation Diltiazem was administered from 04/01/22 through 04/22/22 and on 04/26/22. -Doses of Diltiazem on 04/23/22, 04/24/22, 04/25/22, 04/27/22, 04/28/22 and 04/29/22 were documented on hold. -On 04/30/22 the Diltiazem was not administered because the resident was hospitalized. Review of Resident #2's May 2022 eMAR revealed: -There were two entries for Diltiazem ER 240mg daily at 8:00am. -From 05/01/22 through 05/04/22 there was documentation Diltiazem was not administered due to hospitalization. -On 05/05/22 the Diltiazem was documented on hold. Review of Resident #2's April 2022 electronic progress notes revealed: -There were entries on 04/05/22 at 8:47am, 04/12/22 at 9:16am, and 04/26/22 at 2:25pm that cart audits had been completed. -There was no documentation the resident was low or out of Diltiazem as a result of the audit. -There was no documentation the pharmacy or the resident's primary care provider (PCP) were notified about Diltiazem.	{D 358}		

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{D 358}	Continued From page 15 Interview with a medication aide (MA) on 05/18/22 at 10:33am revealed: -When medications were not available from the pharmacy, the MA faxed a hold request order to the primary care provider (PCP) or the Resident Care Coordinator (RCC) emailed the PCP the same day. -Residents' medications were automatically filled on monthly cycle fills. -If a medication got down to 10 remaining doses, the MA faxed or scanned a refill request to the pharmacy. -Sometimes medications were not available because the pharmacy was late in delivering medications. -She did not remember why Resident #2's Diltiazem was on hold when she administered his morning medications on 04/28/22. -She could not remember if the Diltiazem was not available from the pharmacy on 04/28/22. Interview with a second MA on 05/18/22 at 10:44am revealed: -She did not remember why Resident #2's Diltiazem was held when she administered his morning medications on 04/23/22 and 04/24/22. -She did not want to document the medication was refused, so she documented the medication was on hold when a medication was not in the building. -When a medication was placed on hold, she contacted the pharmacy. -She was sure she called the pharmacy about Resident #2's Diltiazem but she did not remember what was said. -There could have been an issue with the order. -She usually contacted the pharmacy, documented a progress note and reported to the RCC when a medication was not available. -She did not document a progress note on the	{D 358}		

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{D 358}	Continued From page 16 resident's electronic record for 04/23/22 or 04/24/22 regarding contact with the pharmacy. Telephone interview with a third MA on 05/18/22 at 4:14pm revealed: -She was not sure what the issue was with Resident #2's Diltiazem. -She did not call the pharmacy about his Diltiazem. -She did not tell the RCC the resident's Diltiazem was not available from the pharmacy. -She did not know if any other MA had contacted the pharmacy or talked to the RCC. -There should have been a progress note if the pharmacy was contacted. -She may have documented the Diltiazem was on hold on 04/25/22 and 04/27/22 but administered on 04/26/22 because she may not have seen it on the cart and then did see it. Second interview with the first MA on 05/18/22 at 2:25pm revealed she documented Resident #2's Diltiazem was held on 05/05/22 because she did not check the overstock drawer. Interview with the RCC on 05/18/22 at 9:08am revealed: -Medications were placed on hold for various reasons including waiting for the medication to come from the pharmacy. -MAs placed the medication on hold when the medication was not available for administration and then contacted the PCP to sign an order to hold the medication. Interview with the RCC on 05/18/22 at 9:36am revealed she did not find a signed order from the PCP to hold Resident #2's Diltiazem from 04/23/22 through 04/29/22.	{D 358}		

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{D 358}	Continued From page 17 Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/18/22 at 11:01am revealed: -Resident #2 was a new admission to the facility on 03/15/22. -He had an order for Diltiazem ER 240mg daily dated 03/15/22. -The staff requested the pharmacy not dispense any Diltiazem for the resident on 03/15/22. -The staff would request Diltiazem for the resident as needed. -The pharmacy dispensed 28 tablets of Diltiazem for Resident #2 on 03/25/22. -The 28 tablets were not dispensed all at one time but in 7-day increments in multidose packs (MDPs). -On 05/05/22 the pharmacy dispensed 7 tablets of Diltiazem in a bubble pack and 7 tablets in a MDP on 05/13/22. -MDP were processed by the pharmacy weekly. -The pharmacy contacted the facility one week in advance of needing a new order. -The pharmacy would dispense an emergency supply or a courtesy refill for life saving medications. -She did not know what happened with Resident #2's Diltiazem from 04/23/22 to 04/29/22. -The 28 tablets dispensed on 03/25/22 would have been available to administer until 04/23/22 or 04/24/22. -There might have been a problem with the orders for Resident #2 because she was showing there were not signed orders until 05/04/22. -The resident was transferred from a sister facility and his orders from that facility migrated with him for one month while the facility awaited new signed orders from the new PCP. -Diltiazem was used to treat high blood pressure and cardiac issues and not taking it could result in increased blood pressure.	{D 358}		

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{D 358}	Continued From page 18 Interview with the RCC on 05/18/22 at 12:04pm revealed: -The MAs did not let her know Resident #2 was out of Diltiazem, she found out while the resident was hospitalized. -She completed a medication cart audit and found his Diltiazem in the overstock drawer. -She did not remember when she did the medication cart audit and found the Diltiazem. -MAs were responsible for re-ordering medications when the medications were down to the last row of a bubble pack. -If medications were not received in the facility within 2 days, the MAs were supposed to notify her. -MDPs were automatically cycle filled each week. -If a medication was not included in the MDP, the MA notified the pharmacy that day and if the medication was not received within 1 day, the MA was supposed to notify her. Interview with the Administrator on 05/18/22 at 12:48pm revealed: -He became aware Resident #2 was out of Diltiazem the day before the resident returned from the hospital (05/03/22). -The problem was because the MA did not thoroughly check the overstock drawer for the Diltiazem. -He did not know there was no signed order to hold the resident's Diltiazem. Refer to telephone interview with a medication aide (MA) on 05/18/22 at 4:14pm. Refer to telephone interview with Resident #1's and Resident #3's PCP on 05/18/22 at 3:10pm. Refer to interview with the Administrator on	{D 358}		

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{D 358}	Continued From page 19 05/18/22 at 12:48pm. Refer to interview with the Administrator on 05/18/22 at 6:10pm. 2. Review of Resident #3's current FL-2 dated 03/09/22 revealed diagnoses included hypertension, major depressive disorder and immunodeficiency. Review of Resident #3's April 2022 electronic progress notes revealed: -There were entries on 04/14/22 at 8:39am, 04/21/22 at 5:30pm, and 04/28/22 at 10:30pm that cart audits had been completed. -There was no documentation the resident was low or out of any medications as a result of the audit. -There was no documentation the pharmacy and/or the resident's primary care provider (PCP) were notified about medications that were not available from the pharmacy. Review of Resident #3's May 2022 electronic progress notes revealed: -There was an entry on 05/05/22 at 9:56pm that a cart audit had been completed. -There was no documentation the resident was low or out of any medications as a result of the audit. -There was no documentation the pharmacy and/or the resident's primary care provider (PCP) were notified about medications that were not available from the pharmacy. a. Review of Resident #3's current FL-2 dated 03/09/22 revealed an order for sertraline 25mg daily. (Sertraline is used to treat depression and anxiety.)	{D 358}		

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Review of Resident #3's physician's order review dated 04/27/22 revealed an order for sertraline 25mg daily.

Interview with the Resident Care Coordinator (RCC) on 05/18/22 at 3:46pm revealed there were no hold orders for Resident #3's sertraline.

Review of Resident #3's March 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for sertraline 25mg daily at 8:00am starting 03/15/22.
-There was documentation sertraline was administered from 03/16/22 through 03/31/22 except 03/22/22.
-There documentation the resident refused sertraline on 03/22/22.

Review of Resident #3's April 2022 eMAR revealed:
-There was an entry for sertraline 25ng daily at 8:00am.
-There was documentation sertraline was administered from 04/01/22 through 04/18/22 and 04/20/22 through 04/26/22.
-Sertraline on 04/19/22 and 04/27/22 through 04/30/22 were documented as on hold.

Review of Resident #3's May 2022 eMAR revealed:
-There were 2 entries for sertraline 25mg daily at 8:00am.
-There was documentation sertraline was administered from 05/03/22 through 05/17/22.
-There was documentation sertraline was on hold on 05/01/22 and 05/02/22.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/18/22 at

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{D 358}	Continued From page 21 4:47pm revealed: -The pharmacy dispensed 21 sertraline tablets on 03/25/22 for Resident #3 which would have lasted until 04/11/22. -The pharmacy did not have bill dates of additional sertraline tablets dispensed between 03/25/22 and 05/06/22 when the resident was set up on the multidose packs (MDPs). -The pharmacy dispensed 7 tablets of sertraline in a bubble pack on 05/13/22 because it was missing from the MDPs on 05/06/22. Interview with the RCC on 05/18/22 at 5:35pm revealed: -She did not know Resident #3 was out of sertraline in April and May 2022. -The MAs should have let her know at least after 3 days of the medication not being available from the pharmacy because she could have resolved the issue with a phone call to the pharmacy. b. Review of Resident #3's current FL-2 dated 03/09/22 revealed an order for potassium chloride 20mEq daily. (Potassium chloride is used to replace low levels of potassium in the blood.) Review of Resident #3's physician's order review dated 04/27/22 revealed an order for potassium chloride 20mEq daily. Interview with the Resident Care Coordinator (RCC) on 05/18/22 at 3:46pm revealed there were no hold orders for Resident #3's potassium chloride. Review of Resident #3's March 2022 electronic medication administration record (eMAR) revealed: -There was an entry for potassium chloride 20mEq daily at 7:30am starting 03/15/22.	{D 358}		

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{D 358}	Continued From page 22 -There was documentation potassium chloride was administered from 03/16/22 through 03/31/22 except 03/22/22. -There documentation the resident refused potassium chloride on 03/22/22. Review of Resident #3's April 2022 eMAR revealed: -There was an entry for potassium chloride 20mEq daily at 7:30am. -There was documentation potassium chloride was administered from 04/01/22 through 04/18/22 and 04/20/22 through 04/22/22. -Potassium chloride on 04/19/22, 04/23/22 through 04/30/22 were documented as on hold. Review of Resident #3's May 2022 eMAR revealed: -There were 2 entries for potassium chloride 20mEq daily at 7:30am. -There was documentation potassium chloride was administered from 05/03/22 through 05/17/22. -There was documentation potassium chloride was on hold on 05/01/22 and 05/02/22. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/18/22 at 4:47pm revealed: -The pharmacy dispensed 7 potassium chloride tablets on 03/15/22 for Resident #3 and 21 tablets on 03/25/22. -There was no record of additional dispenses of potassium chloride for the resident. Telephone interview with Resident #3's PCP on 05/18/22 at 3:10pm revealed she was not concerned with Resident #3 missing doses of potassium chloride on 04/19/22, 04/23/22 through 04/30/22, 05/01/22 and 05/02/22.	{D 358}		

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{D 358}	Continued From page 23 Interview with the RCC on 05/18/22 at 5:35pm revealed: -She did not know Resident #3 was out of potassium chloride on 04/19/22, 04/23/22 through 04/30/22, 05/01/22 and 05/02/22. -The MAs should have let her know at least after 3 days of the medication not being available from the pharmacy because she could have resolved the issue with a phone call to the pharmacy. c. Review of Resident #3's current FL-2 dated 03/09/22 revealed an order for Atripla 1 tablet daily. (Atripla is used to treat viral infections.) Review of Resident #3's physician's order review dated 04/27/22 revealed an order for Atripla 1 tablet daily. Interview with the Resident Care Coordinator (RCC) on 05/18/22 at 3:46pm revealed there were no hold orders for Resident #3's Atripla. Review of Resident #3's March 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Atripla 1 tablet daily at 8:00am starting 03/17/22. -There was documentation Atripla was administered from 03/17/22 through 03/31/22. -There were no missed or refused doses of Atripla documented. Review of Resident #3's April 2022 eMAR revealed: -There was an entry for Atripla 1 tablet daily at 8:00am. -There was documentation Atripla was administered from 04/03/22 through 04/18/22, 04/21/22, 04/22/22, 04/27/22 and on 04/28/22.	{D 358}		

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{D 358}	Continued From page 24 -Doses of Atripla on 04/19/22, 04/20/22, 04/23/22, 04/24/22, 04/25/22, 04/26/22 and 04/29/22 were documented on hold. -There was documentation Atripla was not administered on 04/01/22 and 04/02/22 because the resident refused. Review of Resident #3's May 2022 eMAR revealed: -There was an entry for Atripla 1 tablet daily at 8:00am. -There was documentation Atripla was administered from 05/01/22 through 05/17/22. -There were no missed or refused doses of Atripla documented. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/18/22 at 4:47pm revealed the pharmacy dispensed 30 Atripla tablets on 03/11/22 at Resident #3's previous facility and 30 tablets on 05/01/22. Telephone interview with Resident #3's PCP on 05/18/22 at 3:10pm revealed: -She was concerned about the resident missing doses of Atripla which was why she ordered a viral load which was still undetectable. -Missing doses of Atripla could cause an increased viral load in the blood. Interview with the RCC on 05/18/22 at 5:35pm revealed: -She did not know Resident #3 was out of Atripla in April 2022. -The MAs should have let her know at least after 3 days of the medication not being available from the pharmacy because she could have resolved the issue with a phone call to the pharmacy. d. Review of Resident #2's physician order dated	{D 358}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 25 03/30/22 revealed an order for Exforge 1 tablet daily. (Exforge is used to treat high blood pressure.) Review of Resident #3's physician's order review dated 04/27/22 revealed an order for Exforge 1 tablet daily. Interview with the Resident Care Coordinator (RCC) on 05/18/22 at 3:46pm revealed there were no hold orders for Resident #3's Exforge. Review of Resident #3's March 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Exforge 1 tablet daily at 8:00am starting 03/30/22. -There were no doses documented as administered. -On 03/31/22 there was documentation the Exforge was discontinued. Review of Resident #3's April 2022 eMAR revealed: -There were 3 entries for Exforge 1 tablet daily at 8:00am. -There was documentation Exforge was administered from 04/04/22 through 04/18/22 and 04/22/22 through 04/30/22. -There was documentation Exforge was not administered on 04/01/22 through 04/02/22 because the resident refused. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/18/22 at 4:47pm revealed the pharmacy dispensed 8 tablets of Exforge on 03/30/22, 7 tablets on 04/12/22 and 28 tablets on 04/22/22 for Resident #3.	{D 358}		

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	HAL077010	A. BUILDING: _____ B. WING _____	R 05/18/2022

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{D 358}	Continued From page 26 Telephone interview with Resident #3's PCP on 05/18/22 at 3:10pm revealed Resident #3 missing doses of Exforge from 04/19/22 through 04/21/22 was not concerning. Interview with the RCC on 05/18/22 at 5:35pm revealed: -She did not know Resident #3 was out of Exforge from 04/19/22 through 04/21/22. -The MAs should have let her know at least after 3 days of the medication not being available from the pharmacy because she could have resolved the issue with a phone call to the pharmacy. Refer to telephone interview with a medication aide (MA) on 05/18/22 at 4:14pm. Refer to telephone interview with Resident #1's and Resident #3's PCP on 05/18/22 at 3:10pm. Refer to interview with the Administrator on 05/18/22 at 12:48pm. Refer to interview with the Administrator on 05/18/22 at 6:10pm. _____ Telephone interview with a medication aide (MA) on 05/18/22 at 4:14pm revealed: -When she noticed a medication barcode strip had been removed from the package, she knew the medication had been reordered from the pharmacy. -If the medication was not received after one day, MAs called the pharmacy and the primary care provider (PCP) if a new order was needed. Telephone interview with Resident #1's and Resident #3's PCP on 05/18/22 at 3:10pm revealed: -The facility was having problems getting	{D 358}		

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{D 358}	Continued From page 27	{D 358}		

medication in a timely manner from the pharmacy.
-Staff had made her aware of "a lot" of medication issues.
-She did not know which specific medications for Resident #3 staff had reported to her or when it was reported.
-When a medication was not available from the pharmacy the staff faxed her a hold order request which also constituted notification.

Interview with the Administrator on 05/18/22 at 12:48pm revealed:
-MAs were expected to call the pharmacy and notify the PCP if a resident's medications ran out.
-MAs were supposed to document the contact with the pharmacy and the PCP in the progress notes.
-Typically, when medications ran out staff placed the medication on hold and the PCP signed off on the hold order.
-There should be some way for staff to document medications were not available from the pharmacy rather than documenting the medication was held.

Interview with the Administrator on 05/18/22 at 6:10pm revealed:
-Medication cart audits were done daily on random residents by MAs and the RCC did similar medication cart audits twice weekly.
-The facility's support nurse and the pharmacy completed quarterly audits on residents' medications.
-He had a compliance report that he reviewed to ensure orders were in place and residents' medications were in the building.
-The issue causing a failure of medications not being administered as ordered was the MAs needing re-education on checking the overstock

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{D 358}	Continued From page 28 drawer and follow up with the pharmacy and RCC when needed. 3. Review of Resident #1's current FL-2 dated 03/17/22 revealed: -Diagnoses included Type 2 diabetes and neuropathy. -Ordered medications included Trulicity 1.5mg injection once a week on Mondays (Trulicity is used to control diabetes). Review of Resident #1's March 2022 Medication Administration Record (eMAR) revealed an entry for Trulicity 1.5mg injection once a week on Mondays was documented as administered on 03/21 and 03/28. Review of Resident #1's April 2022 eMAR revealed: -An entry for Trulicity 1.5mg injection once a week on Mondays was documented as administered on 04/04, 04/11, and 04/18. -There was documentation that Trulicity was held on 04/25. Review of Resident #1's May 2022 eMAR revealed: -An entry for Trulicity 1.5mg injection once a week on Mondays was documented as administered on 05/09 and 05/16. -There was documentation that Trulicity was held on 05/02. Review of Resident #1's March 2022-May 2022 progress notes did not reveal any documentation of why the medication was held. Observation on 05/18/22 at 2:54pm revealed: -There were two doses of Trulicity 1.5mg in the facility for Resident #1.	{D 358}		

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{D 358}	Continued From page 29	{D 358}		

-The prescription label on one pen indicated it was one of four pens dispensed on 03/01/22.
-The prescription label on the other pen indicated it was one of three pens dispensed on 03/16/22.
-There were no other injection pens in the facility.

Interview with a medication aide (MA) on 05/18/22 at 2:54pm revealed:
-Resident #1 was compliant with taking her medications.
-She did not know why the medication was held.

Interview with Resident #1 on 05/18/22 at 3:35pm revealed she did not remember not receiving her shot those days.

Interview with the Resident Care Coordinator (RCC) on 05/18/22 at 5:54pm revealed:
-Trulicity was held on 04/25 and 05/02 because the MA thought there was none available.
-She did not realize the medication was kept in the refrigerator.
-The pharmacy had dispensed 4 doses on 03/01 and 3 doses on 03/16 and each injection pen was one dose.
-Nine doses should have been given since 03/16/22, which would mean the medication would have run out and been refilled before the 05/09 dose could have been given.
-She did not know why the number of doses dispensed, the number of doses on hand, and the number of doses documented as administered did not add up to the amount dispensed by the pharmacy.

Telephone interview with the facility's contract pharmacist on 05/18/22 at 3:55pm revealed:
-Trulicity was used for blood sugar and diabetic control.
-The pharmacy had dispensed 4 doses on 03/01

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{D 358}	Continued From page 30	{D 358}		

and 3 doses on 03/16 and each injection pen was one dose.
-There was no refill request from the facility since 03/16/22.
-The last dose should have been given on 04/25/22.
-Trulicity was used for blood sugar management and Resident #1 was at risk of high blood sugars and a coma if diabetic medications were missed.

Telephone interview with Resident #1's primary care provider on 05/18/22 at 4:35pm revealed Resident #1 took Trulicity for blood sugar management and needed it weekly to avoid having high blood sugars.

4. Review of Resident #5's current FL-2 dated 02/28/22 revealed:
-Diagnoses included hypertension, Type 2 diabetes, and chronic obstructive pulmonary disease.
-Orders included nitroglycerin 0.4mg one pill under the tongue as needed for chest pain.

Observation of Resident #5's medications on hand on 05/18/22 at 2:48 pm revealed no supply of nitroglycerin was available for Resident #5.

Interview with a Medication Aide (MA) on 05/18/22 at 2:51pm revealed:
-There was no nitroglycerin available for Resident #5.
-The medication may have expired and was discarded.
-Medications should be reordered 1-3 days before expiration.

Interview with the Resident Care Coordinator on 05/18/22 at 5:33pm revealed medications should be reordered immediately so it could be delivered

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{D 358}	Continued From page 31 the same day. Telephone interview with the facility's contract pharmacist on 05/18/22 at 3:55pm revealed: -There was a current order on file for nitroglycerin 0.4mg one pill under the tongue as needed for chest pain. -The pharmacy had last dispensed the medication on 10/01/21. -The facility had not requested it be refilled. -The pharmacy had sent refill requests to the facility that had not been addressed. Telephone interview with Resident #5's primary care provider on 05/18/22 at 4:35pm revealed: -Resident #5 was only her patient for 3 weeks. -She was not aware of him not having nitroglycerin if needed. _____ The facility failed to administer medications as ordered by the prescribing practitioner for 4 of 5 residents including Resident #2 who did not receive Diltiazem used to treat cardiac arhythmias for 7 days. The facility's failure to administer Diltiazem as ordered for Resident #2 resulted in the resident being hospitalized for atrial fibrillation with rapid ventricular response (rapid heart rate) and congestive heart failure. This failure resulted in substantial risk of serious harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/18/22 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 17, 2022.	{D 358}		

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{D912}	Continued From page 32	{D912}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to health care and medication administration. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to notify the primary care provider (PCP) for 2 of 5 sampled residents (#1 and #2) for complaints of increased shortness of breath and heart palpitations in addition to the resident not receiving a cardiac medication for 7 days (#2) and for repeated refusals of medications for diabetes, pain, and electrolyte imbalances (#1) [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Unabated Type A2 Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered by the prescribing practitioner for 4 of 5 sampled residents (#1, #2, #3 and #5) including medications for cardiac arrythmias (#2), medication for diabetes (#1), a medication for chest pain (#5); and medications	{D912}		

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{D912}	Continued From page 33 for depression and hypertension, an antiviral medication and a supplement (#3) [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].	{D912}		