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BETHAMY RETIREMENT CENTER	**909 N SALISBULRY AVENUE SPENCER, NC 28159**

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey from 04/11/23 to 04/12/23 with an exit via telphone on 4/13/23.	D 000		
D 238	10A NCAC 13F .0703 (c-4) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: (4) If the information on the FL-2 or MR-2 is not clear or is insufficient, the facility shall contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure 1 of 5 sampled residents (#1) FL2 included complete information with a current list of medication orders. The findings are: Review of Resident #1's current FL2 dated 11/21/22 revealed: -Diagnoses included neurogenic bladder, diabetes, neuroleptic-induced Parkinson's, and paranoid schizophrenia. -There was an order for semaglutide (a medication used to treat diabetes) 1mg/0.75mL,	D 238		

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inject 1mg subcutaneously once weekly.
-There was an order for tamsulosin (a medication used to treat urinary retention) 0.4mg twice daily.
-There was an order for tiotropium (an inhaled bronchodilator medication) 2.5mcg inhale 2 puffs once daily.
-There was an order for trazodone (a sedative medication) 100mg at bedtime.
-There was an order for trihexyphenidyl (a medication used to treat symptoms of Parkinson's disease such as tremors, spasms, stiffness, and weak muscle control) 2mg three times daily.
-There was an order for fluticasone (a steroidal nasal spray) 50mcg, instill 1 spray into each nostril twice daily.
-There was an order for psyllium powder (used to relieve constipation) take 1 teaspoonful daily.
There was an order for umeclidinium (an inhaled anticholinergic medication to manage chronic obstructive pulmonary disease) 62.5mcg, inhale 1 puff daily.
-There were no other medications listed or pages of the FL2 available in the record to review.

Review of Resident #1's updated physician's orders dated 02/06/23 that was not included on the FL2 dated 11/21/22 revealed:
-An order for ibuprofen 200mg (an over-the-counter medication used to treat pain) every 8 hours as needed had a start date of 09/05/22.
-An order for acetaminophen 500mg (an over-the-counter medication used to treat pain or fever) every 8 hours as needed had a start date of 09/05/22.
-An order for melatonin 10mg (a supplement used as a sleep-aid) at bedtime had a start date of 09/07/22.
-An order for docusate sodium/senna

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D 238	Continued From page 2 50mg/8.6mg (a stool softener used to treat constipation) take two tablets twice daily had a start date of 09/07/22. -An order for cetirizine 10mg (an antihistamine used to treat allergy symptoms) daily had a start date of 09/05/22. -An order for famotidine 20mg (an antacid used to treat acid reflux) at bedtime had a start date of 09/05/22. -An order for cholecalciferol 25mcg (a vitamin D supplement used to treat low vitamin D levels) daily had a start date of 09/05/22. -An order for rosuvastatin 40mg (used to treat high cholesterol) take one-half tablet daily had a start date of 09/05/22. -An order for metformin 1000mg (an oral medication used to treat diabetes) twice daily had a start date of 09/05/22. -An order for lisinopril 20mg (used to treat high blood pressure or heart failure) daily had a start date of 09/05/22. -An order for cyanocobalamin 500mcg (a vitamin B supplement used to treat low vitamin B levels) daily had a start date of 09/05/22. -An order for bisacodyl 5mg (a laxative used to treat constipation) daily as needed had a start date of 09/05/22. -An order for aspirin 81mg (a non-steroidal anti-inflammatory medication used to treat pain or fever or reduce the risk of heart attack) daily had a start date of 09/05/22. -An order for metoprolol 50mg (a beta blocker medication used to treat high blood pressure) twice daily had a start date of 09/30/22. -An order for levetiracetam 750mg (an anticonvulsant used to prevent seizures) twice daily had a start date of 09/07/22. -Resident #1's order for Novolog insulin (a rapid-acting insulin used to treat high blood sugar) inject 50 units subcutaneously twice daily	D 238		

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D 238	Continued From page 3 with meals had a start date of 09/07/22. Telephone interview with the Resident Care Director (RCD) on 04/13/23 at 2:45pm revealed: -Resident #1's Veteran's Administration (VA) primary care provider (PCP) prepared his FL2 and she had not noticed that it was missing 16 of his medications that were current and active at the time the FL2 was created. -Resident #1 had been receiving all of his prescribed medications. -She was responsible for reviewing and processing the residents' FL2s. -If there was supposed to be another page to Resident #1's FL2 she did not have it. Attempted telephone interview with Resident #1's VA PCP on 04/13/23 at 12:40pm was unsuccessful. Attempted telephone interviews with the Administrator on 04/13/23 at 4:12pm and 4:48pm were unsuccessful.	D 238		
D 259	10A NCAC 13F .0802(a) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) An adult care home shall assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within 30 days following admission according to Rule .0801 of this Section. The care plan is an individualized, written program of personal care for each resident. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents	D 259		

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(#1) had a care plan completed within 30 days of admission.

The findings are:

Review of Resident #1's current FL2 dated 11/21/22 revealed:
-Diagnoses included diabetes, neuroleptic-induced Parkinson's, neurogenic bladder and paranoid schizophrenia.
-Resident #1 was semi-ambulatory.
-Resident #1 was on a bowel and bladder program.

Review of Resident #1's Resident Register dated 08/07/22 revealed he was admitted to the facility on 08/07/22.

Review of Resident #1's record revealed:
-There was no care plan available for review.
-Resident #1 had a catheter upon admission which was removed 02/28/23 and replaced with a toileting schedule of every 2 hours.

Interview with Resident #1 on 04/11/23 at 3:30pm revealed:
-He was independent with eating, ambulating with his walker, transferring and toileting.
-The staff helped him with bathing and sometimes with personal hygiene.

Interview with a personal care aide (PCA) on 04/12/23 at 2:40pm revealed:
-The staff assisted Resident #1 with showering.
-Resident #1 was able to go to the bathroom without assistance, but staff had to monitor his urine output every two hours.
-Resident #1 was independent with the rest of his personal care.

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D 259	Continued From page 5 Telephone interview with the Resident Care Director (RCD) on 04/13/23 at 2:45pm revealed: -She was responsible for completing the residents' care plans and was aware they needed to be completed within 30 days of a resident's admission to the facility. -Since starting her position, she had not had the time to audit the residents' records to check that all the residents had current care plans. -She was not aware Resident #1 did not have a care plan in his record. Attempted telephone interview with Resident #1's Veteran's Administration (VA) primary care provider (PCP) on 04/13/23 at 12:40pm was unsuccessful. Attempted telephone interviews with the Administrator on 04/13/23 at 4:12pm and 4:48pm were unsuccessful. Attempted telephone interview with the facility's Owner on 04/13/23 at 4:39pm was unsuccessful.	D 259		
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 B VIOLATION Non-compliance continues with increased severity resulting in residents placed at substantial risk that death or serious physical harm, abuse, neglect or exploitation will occur.	D 273		

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THIS IS A TYPE A2 VIOLATION

Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 5 sampled residents (Resident #4) related to the facility's failure to notify the primary care provider (PCP) regarding high and low fingerstick blood sugars (FSBS), refer to endocrinology for management of finger stick blood sugars (FSBS) and to home health for management of his Foley catheter; and follow-up with the nephrologist, nephrologist, urologist, endocrinologist, and a physician assistant (PA) as ordered.

The findings are:

Review of Resident #4's current FL2 dated 04/08/23 revealed diagnoses included blindness, diabetes mellitus, history of kidney transplant, history of pancreas transplant, heart murmur, history of eye removal, hypertension, and schizophrenia.

a. Review of Resident #4's current FL2 dated 04/08/23 revealed:
-Resident #4 was hospitalized from 04/06/23 through 04/08/23.
-The hospital diagnoses included diabetic ketoacidosis without coma associated with type 2 diabetes, nausea and vomiting.

Review of Resident #4's physician's orders dated 07/21/22 revealed:
-There was an order for Novolog sliding scale insulin (SSI) (a rapid-acting insulin used to lower elevated blood sugar levels) with breakfast, lunch, and dinner: 151-200= 2 units, 201-250= 4 units, 251-300=6 units, 301-350= 8 units, 351-400= 10 units, 401-500= 15 units.

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-There were no directions what to do if Resident #4's fingerstick blood sugars (FSBS) were greater than 500.

Review of Resident #4's hospital discharge summary dated 02/17/23 revealed:
-Resident #4 presented to the emergency room on 02/14/23 with blood sugars above 500, hemoglobin A1C (HbA1c) of 9.9%, and confusion. (HbA1c is a blood test that measures the average FSBS levels over the past 3 months. The normal range for HbA1c is between 4% and 5.6%.)
-Resident #4 was hospitalized from 02/14/23 to 02/17/23
-Resident #4's blood sugar upon discharge was 300.

Review of Resident #4's Primary Care Provider's (PCP) progress note dated 03/02/23 revealed:
-There was an order for Novolog flex pen 100u/ml, check FSBS before each meal and inject per SSI: 151-200= 2 units; 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, 401-500= 15 units; greater than 500= notify medical provider.
-There were no further instructions.

Review of Resident #4's hospital discharge summary dated 03/03/23 revealed:
-Resident #4 was admitted to the hospital on 02/24/23 and discharged on 03/03/23.
-Resident #4 had uncontrolled type 1 diabetes and was hyperglycemic with blood glucose greater than 700 at one point during hospitalization.
-Resident #4's blood glucose ranged from 150 to 200 prior to discharge.
-Resident #4 needed close follow-up with his PCP as well as endocrinology.

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Review of the facility's contracted PCPs insulin protocols (undated) revealed:
-There were protocols in place for high and low FSBS after hours to minimize non-urgent calls to the on-call provider.
-There were directions for what the facility staff should do after hours if a resident was symptomatic or had a SSI with instructions to call the physician if the FSBS were above a specified number.
-There were no directions of what facility staff should do after hours for high blood sugars if there were no instructions in the resident's insulin order to call the physician.
-If the resident's FSBS was below 70 after hours, staff was to contact the physician after 3 attempts to raise the FSBS by holding rapid acting insulin; giving 8 ounces of juice, soda, and snack; repeat FSBS in 15 minutes and if FSBS was still less than 70 and the resident was alert, give additional 4 ounces of juice and another snack; repeat FSBS in another 15 minutes, and if FSBS was still less than 70, repeat 1 more time.
-The protocols did not include any information on what staff should do during regular business hours when a resident's FSBSs were high or low.

Review of Resident #4's electronic Medication Administration Record (eMAR) for February 2023 revealed:
-There was an entry for Novolog flex pen 100u/mL, check FSBS before each meal and inject per sliding scale insulin (SSI): 151-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, 401-500= 15 units scheduled for administration at 7:30am, 11:30am, and 4:30pm.
-Resident #4's FSBS was documented as 40 on 02/10/23 at 11:30am and no insulin was documented as administered; there was

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documentation the MA gave Resident #4 orange juice and would recheck the FSBS in 30 minutes, but there was no documentation of a recheck of Resident #4's FSBS.
-There was no documentation on 02/13/23, 02/14/23, or on 02/22/23, when Resident #4's FSBS ranged from 503 to 586, that the MA contacted Resident #4's PCP, no documentation of any interventions, nor documentation of a recheck of Resident #4's FSBS.
-There was no protocol available for review for staff guidance for FSBS above 500 or below 70 during regular business hours.
-Resident #4's FSBSs ranged from 40 to 586 from 02/01/23 through 02/28/23.

Review of Resident #4's progress notes for February 2023 revealed:
-There was no documentation regarding FSBS, insulin administration, or contact with Resident #4's PCP on 02/10/23, 02/13/23, or 02/22/23.
-On 02/14/23, there was documentation Resident #4's FSBS had been high since 4:00pm and was recorded at 537 and proper protocol for insulin was followed (There was no documentation what the protocol was).

Review of Resident #4's eMAR for March 2023 revealed:
-There was an entry for Novolog flex pen 100u/mL, check FSBS before each meal and inject per sliding scale insulin (SSI): 151-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, 401-500= 15 units scheduled for administration at 7:30am, 11:30am, and 4:30pm.
-There was no documentation on 03/07/23, 03/11/23, 03/14/23, 03/17/23, 03/25/23, 03/26/23, 03/28/23, 03/30/23 at 4:30pm, or on 03/31/23, when Resident #4's FSBS ranged from 37 to 599,

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that the MA contacted Resident #4's PCP, no documentation of any interventions, nor documentation of a recheck of Resident #4's FSBS.
-There was no protocol available for review for staff guidance for FSBS above 500 or below 70 during regular business hours.
-Resident #4's FSBSs ranged from 37 to 599 from 03/01/23 through 03/31/23.

Review of Resident #4's progress notes for March 2023 revealed:
-There was no documentation regarding FSBS, insulin administration, or contact with Resident #4's PCP on 03/11/23, 03/14/23, 03/17/23, 03/25/23, 03/26/23, 03/28/23, 03/30/23 at 4:30pm, or on 03/31/23.
-On 03/30/23 at 12:09pm, there was documentation Resident #4's FSBS was low and the MA gave Resident #4 orange juice and would recheck it after lunch on 03/30/23, but there was no documentation the MA rechecked Resident #4's blood sugar.

Review of Resident #4's eMAR for 04/01/23 through 04/05/23 revealed:
-There was an entry for Novolog flex pen 100u/mL, check FSBS before each meal and inject per sliding scale insulin (SSI)): 151-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units , 351-400= 10 units, 401-500= 15 units scheduled for administration at 7:30am, 11:30am, and 4:30pm.
-There was no documentation on 04/02/23, when Resident #4's FSBS was 48, that the MA contacted Resident #4's PCP, no documentation of any interventions, nor documentation of a recheck of Resident #4's FSBS.
-There was no protocol available for review for staff guidance for FSBS above 500 or below 70

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during regular business hours.
-Resident #4's FSBSs ranged from 48 to 499 from 04/01/23 through 04/05/23.

Review of Resident #4's progress notes for 04/01/23 through 04/08/23 revealed there was no documentation regarding FSBS, insulin administration, or contact with Resident #4's PCP on 04/02/3.

Interview with Resident #4 on 04/12/23 at 2:59pm revealed:
-He thought he was administered insulin 3 times daily for diabetes.
-He had recently been hospitalized for high blood sugars, but he did not remember when.

Telephone interview with Resident #4's PCP on 04/13/23 at 11:25am revealed:
-She started seeing residents at the facility 3 weeks ago.
-She saw Resident #4 today, on 04/13/23.
-Resident #4's FSBS were "all over the place."
-She had received multiple notifications regarding Resident #4's FSBS over the last few days, but she could not confirm if there had been notification over the last 3 weeks or prior to her working with the facility.
-She expected the facility to contact her if Resident #4's FSBS were greater than 500 or less than 60.
-Resident #4's SSI was recently discontinued and he did not have a current orders for a SSI; SSI was discontinued on , but she would be making medication changes today, 04/13/23.

Telephone interview with a medication aide (MA) on 04/13/23 at 12:24pm revealed:
-She always double checked the number of units of insulin that were to be administered before she

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administered them.
-She checked Resident #4's FSBS when it was over 500.
-When his FSBS was above 500, she did not administer insulin.
-She contacted Resident #4's PCP when his FSBS were over 500.
-A couple times she was also told to keep an eye on Resident #4 after reporting FSBS over 500.
-If Resident #4's FSBS was below 50, she would give him orange juice and water and recheck his FSBS in 30 minutes.
-She documented notification to the PCP in the residents' progress notes.
-She documented FSBS rechecks on a sheet of paper and sometimes in the residents' progress notes.

Telephone interview with a MA on 04/13/23 at 1:55pm revealed:
-When Resident #4's FSBS was above 500, she administered 15 units of insulin and contacted the PCP.
-She referred to the facility's contracted provider's notebook for insulin protocols and followed them.
-If Resident #4's FSBSs were below 110, she did not give insulin and she called his PCP.
-If she reported low FSBS to the PCP, the PCP told her to hold the insulin, let the resident eat, and recheck the FSBS.
-She documented notification to the PCP and FSBS rechecks in the residents' progress notes.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 04/13/23 at 9:30am revealed:
-Resident #4 had an order for Novolog SSI: 151-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, 401-500= 15 units scheduled for administration at

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7:30am, 11:30am, and 4:30pm.
-Resident #4's Novolog SSI was discontinued on 04/08/23.

Interview with the Resident Care Director (RCD) on 04/12/23 at 3:24pm revealed:
-She expected staff to follow the insulin protocols in the facility's contracted provider's notebook which was available to all MAs.
-Staff documented contact with residents' PCP in the eMAR system or in progress notes.
-If there was no documentation in the residents' progress notes then the PCP was probably not contacted.

Telephone interview with the RCD on 04/13/23 at 2:55pm revealed:
-FSBS rechecks should have been documented in the resident's eMAR notes or in the resident's progress notes.
-There was no other place where staff documented notification to a resident's PCP or FSBS rechecks.
-She expected MAs to contact Resident #4's PCP if his FSBS were over 500 or fell below 70 or 60 and document.

Attempted telephone interviews with the Administrator on 04/13/23 at 4:12pm and 4:48pm were unsuccessful.

Attempted telephone interview with the facility's Owner on 04/13/23 at 4:39pm was unsuccessful.

b. Review of Resident #4's primary care provider's (PCP) physician's note dated 02/22/23 revealed:
-Resident #4 was seen on 02/22/23 at the facility to manage chronic conditions and an acute condition.

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-Resident #4 returned to the facility from the hospital where he had been admitted from 02/14/23 to 02/17/23.
-Resident #4 was admitted to the hospital for hyperglycemia due to uncontrolled type 1 diabetes.
-Resident #4 was discharged from the hospital with a FSBS of 300.
-Resident #4's assessment and plan for chronic diabetes mellitus included refer to endocrinologist.

Review of Resident #4's hospital discharge summary and after visit summary dated 03/03/23 revealed:
-Resident #4 was admitted to the hospital on 02/24/23 and discharged on 03/03/23.
-Resident #4 had uncontrolled type 1 diabetes and was hyperglycemic with blood glucose greater than 700 at one point during hospitalization.
-Blood glucose ranged from 150 to 200 prior to discharge.
-Resident #4 needed close follow-up with his PCP as well as endocrinology.
-There was an order for a referral to Endocrinology for management of type 1 diabetes mellitus and history of pancreas transplant.

Review of Resident #4's hospital after visit summary dated 03/03/23 revealed instructions to follow-up with the ambulatory referral to endocrinology for management of type 1 diabetes mellitus and history of pancreas transplant.

Review of Resident #4's electronic Medication Administration Records (eMARs) for February, March 2023, and from 04/01/23 through 04/05/23 revealed:
-Resident #4's FSBSs ranged from 40 to 586 in

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February 2023.
-Resident #4's FSBSs ranged from 37 to 599 in March 2023.
-Resident #4's FSBSs ranged from 48 to 499 from 04/01/23 through 04/05/23.

Interview with a representative from the endocrinologist's office on 04/12/23 at 2:15pm revealed:
-The endocrinologist's office had not received a referral for Resident #4.
-He did not have an appointment scheduled and had not have any recent appointments.
-Resident #4 had a scheduled appointment in November 2022, but he was a no show and the appointment was not rescheduled.

Interview with Resident #4 on 04/12/23 at 2:59pm revealed he thought it had been about 3 or 4 years since he had seen an endocrinologist.

Interview with the Resident Care Director (RCD) on 04/12/23 at 4:16pm revealed:
-She did not know when Resident #4 was last seen by an endocrinologist.
-She had not made any appointment for Resident #4 with an endocrinologist.
-She, the medication aides (MA), or the transportation staff could have made an appointment with the endocrinologist after receiving the order.
-She did not see any orders for Resident #4 to be referred to an endocrinologist.

Telephone interview with Resident #4's PCP on 04/13/23 at 11:25am revealed:
-She started seeing residents at the facility about 3 weeks ago.
-Resident #4's previous PCP wrote the order for a referral to an endocrinologist for Resident #4 to

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manage his FSBS.
-Resident #4's FSBS were "all over the place."
-She would have expected the facility to follow through with referring Resident #4 to an endocrinologist for management of his diabetes.

Telephone interview with a MA on 04/13/23 at 1:55pm revealed:
-The RCD and the transportation staff were responsible for following up with orders for referrals to outside providers and making appointments.
-She did not know about Resident #4's order to see an endocrinologist.

Attempted telephone interview with the transportation staff on 04/13/23 at 2:54pm was unsuccessful.

Attempted telephone interviews with the Administrator on 04/13/23 at 4:12pm and 4:48pm were unsuccessful.

Attempted telephone interview with the facility's Owner on 04/13/23 at 4:39pm was unsuccessful.

c. Review of Resident #4's primary care provider's (PCP) physician's note dated 02/22/23 revealed:
-Resident #4 was seen on 02/22/23 at the facility to manage chronic conditions and an acute condition.
-Resident #4 returned to the facility from the hospital where he had been admitted from 02/14/23 to 02/17/23.
-Resident #4 was admitted to the hospital for diagnoses which included hydronephrosis of the kidney.
-Resident #4's assessment and plan as a kidney transplant patient included follow up with

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nephrology.

Interview with Resident #4 on 04/12/23 at 2:59pm revealed he had not seen a nephrologist recently.

Interview with the Resident Care Director (RCD) on 04/12/23 at 4:16pm revealed:
-She had not made any appointment for Resident #4 with a nephrologist.
-She, the medication aides (MA), or the transportation staff could have made an appointment with the nephrologist after receiving the order.
-She did not see any orders for Resident #4 to be referred to a nephrologist.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 04/13/23 at 11:25am revealed:
-She started seeing residents at the facility about 3 weeks ago.
-She would have expected Resident #4 to follow up with nephrology as ordered to ensure his kidneys were working properly especially with Resident #4 having the Foley catheter at the time.
-Possible outcomes of not following up with a neurologist included a bladder infection.

Telephone interview with a MA on 04/13/23 at 1:55pm revealed:
-The RCD and the transportation staff were responsible for following up with orders for referrals to outside providers and making appointments.
-She did not know about Resident #4's order to see a nephrologist.

Attempted telephone interview with the transportation staff on 04/13/23 at 2:54pm was unsuccessful.

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Attempted telephone interviews with the Administrator on 04/13/23 at 4:12pm and 4:48pm were unsuccessful.

Attempted telephone interview with the facility's Owner on 04/13/23 at 4:39pm was unsuccessful.

d. Review of Resident #4's primary care provider's (PCP) physician's note dated 02/22/23 revealed:
-There was an order on 02/22/23 for home health to manage Resident #4's Foley catheter.
-Resident #4 was seen on 02/22/23 at the facility to manage chronic conditions and an acute condition.
-Resident #4 returned to the facility from the hospital where he had been admitted from 02/14/23 to 02/17/23.
-Resident #4 was admitted to the hospital for diagnoses which included hydronephrosis of the kidney.
-Resident #4's assessment and plan for hydronephrosis included continuing the Foley catheter and home health was to manage the Foley catheter.

Review of Resident #4's physician's order dated 03/09/23 revealed an order for home health for Foley catheter care and maintenance.

Review of Resident #4's record revealed there were no home health visit notes.

Interview with Resident #4 on 04/12/23 at 2:59pm revealed:
-No one from a home health agency visited him to manage his catheter.
-Facility staff assisted him by emptying his catheter bag daily.

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Telephone interview with a nurse at Resident #4's urologist's office on 04/12/23 at 11:53am revealed:
-Resident #4 was seen in the urologist's office on 04/04/23 as a follow up for hydronephrosis and had his catheter removed during that visit.
-She did not know if the facility was able to manage Resident #4's Foley catheter without assistance from a skilled nurse; it depended on the services the facility was able to provide.

Interview with the Resident Care Director (RCD) on 04/12/23 at 4:16pm revealed:
-She did not see any orders for Resident #4 to be referred to home health for catheter care and maintenance.
-She had not referred Resident #4 to home health.
-She, the medication aides (MA), or the transportation staff could have made the referral to home health.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 04/13/23 at 11:25am revealed:
-She started seeing residents at the facility about 3 weeks ago.
-She expected the facility to have followed through with the previous PCP's order for home health to manage and care for Resident #4's Foley catheter.

Telephone interview with a MA on 04/13/23 at 1:55pm revealed:
-The RCD and the transportation staff were responsible for following up with orders for referrals to outside providers and for making appointments.
-She did not know about Resident #4's

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physician's orders for home health.

Telephone interview with the RCD o 04/13/23 at 5:15pm revealed:
-When Resident #4 had his Foley catheter, staff cleaned around Resident #4's catheter and emptied his catheter bag every 2 hours and as needed.
-Staff cleaned around Resident #4's catheter tubing every time they provided incontinence care.

Attempted telephone interview with the transportation staff on 04/13/23 at 2:54pm was unsuccessful.

Attempted telephone interviews with the Administrator on 04/13/23 at 4:12pm and 4:48pm were unsuccessful.

Attempted telephone interview with the facility's Owner on 04/13/23 at 4:39pm was unsuccessful.

e. Review of Resident #4's hospital discharge summary dated 02/17/23 revealed:
-Resident #4 was found to have hydronephrosis (excess fluid in a kidney due to a backup of urine) of a transplanted kidney.
-Resident #4 required a Foley catheter placement while in the hospital and urology would like for him to follow-up to make sure that hydronephrosis was resolved.

Review of Resident #4's primary care provider's (PCP) physician's note dated 02/22/23 revealed:
-Resident #4 was seen on 02/22/23 at the facility to manage chronic conditions and an acute condition.
-Resident #4 returned to the facility from the hospital where he had been admitted from

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02/14/23 to 02/17/23.
-Resident #4 was admitted to the hospital for diagnoses which included hydronephrosis of the kidney.
-Resident #4's assessment and plan for hydronephrosis included an appointment for urology scheduled for 03/27/23 to ensure that hydronephrosis was resolved.

Review of Resident #4's hospital discharge summary dated 03/03/23 revealed:
-Resident #4 was admitted to the hospital on 02/24/23 and discharged on 03/03/23.
-Resident #4 presented with a history of type 1 diabetes, history of pancreas transplant and kidney transplant, blindness, and schizophrenia.
-Resident #4 had a recent hospitalization for urinary retention, and hydronephrosis with indwelling Foley catheter.
-Resident #4 presented on 02/24/23 with shortness of breath and fever.
-Resident #4 was diagnosed with sepsis secondary to pneumonia and possible urinary tract infection (UTI); he was treated with antibiotics.
-Resident #4 had a follow-up appointment with urology from a prior hospital admission, and was to continue the appointment.
-Resident #4's scheduled appointment with urology was on 03/07/23 at 8:15am.

Telephone interview with a representative in the scheduling department at Resident #4's urologist's office on 04/12/23 at 10:09am revealed:
-Resident #4 had a scheduled appointment on 03/07/23 for a hospital follow up, but he was a no show.
-Resident #4 had an appointment scheduled on 03/27/23 and it was cancelled, but she could not

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Attempted telephone interview with the facility's Owner on 04/13/23 at 4:39pm was unsuccessful.

f. Review of Resident #4's primary care provider's (PCP) physician's note dated 02/22/23 revealed:
-Resident #4 was seen on 02/22/23 at the facility to manage chronic conditions and an acute condition.
-Resident #4 returned to the facility from the hospital where he had been admitted from 02/14/23 to 02/17/23.
-Resident #4 was admitted to the hospital for diagnoses which included hydronephrosis of the kidney, hyperglycemia due to uncontrolled diabetes, and benign prostrate hypertrophy.
-There was an order on 02/22/23 to follow up with a physician assistant (PA) at the family practice office with an appointment scheduled for 03/02/23.

Interview with a representative in the scheduling department at the PA's office on 04/12/23 at 10:24am revealed Resident #4 had a scheduled appointment on 03/02/23, but it was cancelled and not rescheduled.

Interview with the Resident Care Director (RCD) on 04/12/23 at 4:16pm revealed:
-She had not reviewed the order for Resident #4 to be seen by the resident's PA and did not know why there was an order for Resident #4 to be seen by the PA.
-She, the medication aides (MAs) or the transportation staff were responsible for reviewing orders and following up with referrals to outside providers.

Telephone interview with a MA on 04/13/23 at 1:55pm revealed:

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-The RCD and the transportation staff were responsible for following up with orders for referrals to outside providers and for making appointments.
-She did not know about Resident #4's order follow-up with the PA.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 04/13/23 at 11:25am revealed:
-She started seeing residents at the facility about 3 weeks ago.
-She expected the facility to have followed through with all referrals as ordered.

Attempted telephone interview with the transportation staff on 04/13/23 at 2:54pm was unsuccessful.

Attempted telephone interviews with the Administrator on 04/13/23 at 4:12pm and 4:48pm were unsuccessful.

Attempted telephone interview with the facility's Owner on 04/13/23 at 4:39pm was unsuccessful.

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The facility failed to ensure referral and follow up for Resident #4 after having received orders from a local hospital and the previous PCP to refer the resident to an endocrinologist to manage his FSBS resulting in the resident experiencing hypoglycemia and hyperglycemia episodes with FSBS ranging from 40 to 586 between 02/01/23 and 02/28/23, 37 to 599 between 03/01/23 and 03/31/23, and 48 to 499 between 04/01/23 and 04/05/23, and was hospitalized 3 times between February 2023 and April 2023 with diagnoses including diabetic ketoacidosis, uncontrolled type 1 diabetes, and hyperglycemia; there was no documentation the PCP was contacted 13 times

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when the resident's FSBS was greater than 500 or less than 70; there was a referral to an nephrologist and urologist due to the resident's history of having a kidney transplant and a recent hospitalization for hydronephrosis of the transplanted kidney and the referrals were not made which placed the resident at risk for infection; and an order for home health to manage and care for a Foley catheter in place when the resident was discharged from the hospital, which was not referred to home health and the resident had the Foley catheter for 6 weeks without nursing care. This failure placed the residents at risk for serious physical harm and neglect which constitutes an A2 Violation.

____

The facility provided a Plan of Protection in accordance with G.S. 131D-34 on April 12, 2023 for this violation.

CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 13, 2023.

D 358 10A NCAC 13F .1004(a) Medication Administration D 358

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 A1 VIOLATION

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Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 5 sampled residents (#1, #2, and #4) related to medication orders for sliding scale insulin (#4); sliding scale insulin, an antipsychotic medication, and an anti-anxiety medication (#2); an injectable medication used to treat diabetes, an antidepressant medication, a pain medication, a topical antifungal medication, an allergy nasal spray, and an insomnia medication (#1).

The findings are:

1. Review of Resident #4's current FL2 dated 04/08/23 revealed:
-Diagnoses included blindness, diabetes mellitus, history of kidney transplant, history of pancreas transplant, heart murmur, history of eye removal, hypertension, and schizophrenia.
-Hospital diagnoses included diabetic ketoacidosis without coma associated with type 2 diabetes, nausea and vomiting.

Review of Resident #4's physician's orders dated 07/21/22 revealed:
-There was an order for Novolog sliding scale insulin (SSI) (a rapid-acting insulin used to lower elevated blood sugar levels) with breakfast, lunch, and dinner: 151-200= 2 units, 201-250= 4 units, 251-300=6 units, 300-350= 8 units, 351-400= 10 units, 401-500= 15 units.
-There were no directions what to do if Resident #4's fingerstick blood sugars (FSBS) were greater than 500.

Review of Resident #4's hospital discharge summary dated 02/17/23 revealed:
-Resident #4 presented to the emergency room

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on 02/14/23 with blood sugars above 500, hemoglobin A1C (HbA1c) of 9.9%, and confusion. (HbA1c is a blood test that measures the average FSBS levels over the past 3 months. The normal range for HbA1c is between 4% and 5.6%.)
-Resident #4 was hospitalized from 02/14/23 to 02/17/23.
-Resident #4's blood sugar upon discharge was 300.

Review of Resident #4's hospital discharge summary dated 03/03/23 revealed:
-Resident #4 was admitted to the hospital on 02/24/23 and discharged on 03/03/23.
-Resident #4 had uncontrolled type 1 diabetes and was hyperglycemic with blood glucose greater than 700 at one point during hospitalization.
-Blood glucose ranged from 150 to 200 prior to discharge.

Review of Resident #4's Primary Care Provider's (PCP) progress note dated 03/02/23 revealed an order for Novolog flex pen 100u/ml, check FSBS before each meal and inject per SSI: 151-200= 2 units; 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units; greater than 500= notify medical provider.

Review of Resident #4's hospital after visit summary dated 04/08/23 revealed Resident #4 was hospitalized from 04/06/23 to 04/08/23 due to diabetic ketoacidosis without comma associated with diabetes mellitus.

Review of Resident #4's electronic Medication Administration Record (eMAR) for February 2023 revealed:
-There was an entry for Novolog flex pen 100u/mL, check FSBS before each meal and

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inject per SSI: 151-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, 401-500= 15 units scheduled for administration at 7:30am, 11:30am, and 4:30pm.
-On 02/02/23 at 7:30am, there was documentation Resident #4's FSBS was 350 and 6 units of insulin were administered; Resident #4 should have been administered 8 units of insulin.
-On 02/05/23 at 4:30pm, there was documentation Resident #4's FSBS was 326 and 6 units of insulin were administered; Resident #4 should have been administered 8 units of insulin.
-On 02/13/23 at 11:30am, Resident #4's FSBS was 503 and 15 units of insulin were administered, but there was no documentation the MA was instructed by the PCP to give 15 units of insulin.
-On 02/14/23 at 4:30pm, Resident #4's FSBS was 537 and 15 units of insulin were administered, but there was no documentation the MA was instructed by the PCP to give 15 units of insulin.
-On 02/19/23 at 4:30pm, there was documentation Resident #4's FSBS was 356 and 6 units of insulin were administered; Resident #4 should have been administered 10 units of insulin.
-On 02/22/23 at 4:30pm, Resident #4's FSBS was 586 and 15 units of insulin were administered, but there was no documentation the MA was instructed by the PCP to give 15 units of insulin.
-Resident #4's FSBSs ranged from 40 to 586 from 02/01/23 through 02/28/23.

Review of Resident #4's eMAR for March 2023 revealed:
-There was an entry for Novolog flex pen 100u/mL, check FSBS before each meal and

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D 358	Continued From page 29 inject per SSI: 151-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, 401-500= 15 units scheduled for administration at 7:30am, 11:30am, and 4:30pm. -On 03/06/23 at 4:30pm, there was documentation Resident #4's FSBS was 247 and 10 units of insulin were administered; Resident #4 should have been administered 4 units of insulin. -On 03/07/23 at 7:30am, Resident #4's FSBS was 599 and 15 units of insulin were administered, but there was no documentation the MA was instructed by the PCP to give 15 units of insulin. -On 03/12/23 at 4:30pm, there was documentation Resident #4's FSBS was 236 and 2 units of insulin were administered; Resident #4 should have been administered 4 units of insulin. -On 03/15/23 at 4:30pm, there was documentation Resident #4's FSBS was 254 and 4 units of insulin were administered; Resident #4 should have been administered 6 units of insulin. -On 03/27/23 at 4:30pm, there was documentation Resident #4's FSBS was 428 and 10 units of insulin were administered; Resident #4 should have been administered 15 units of insulin. -On 03/29/23 at 4:30pm, there was documentation Resident #4's FSBS was 366 and 8 units of insulin were administered; Resident #4 should have been administered 10 units of insulin. -On 03/30/23 at 4:30pm, Resident #4's FSBS was 517 and 15 units of insulin were administered, but there was no documentation the MA was instructed by the PCP to give 15 units of insulin. -Resident #4's FSBSs ranged from 37 to 599 from 03/01/23 to 03/31/23.	D 358		

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Review of Resident #4's eMAR for 04/01/23 through 04/05/23 revealed:
-There was an entry for Novolog flex pen 100u/mL, check FSBS before each meal and inject per sliding scale insulin (SSI)): 151-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, 401-500= 15 units scheduled for administration at 7:30am, 11:30am, and 4:30pm.
-On 04/04/23 at 11:30am, there was documentation Resident #4's FSBS was 230 and there was no documentation insulin was administered; Resident #4 should have been administered 4 units of insulin.
-Resident #4's FSBSs ranged from 48 to 499 from 4/01/23 to 04/05/23.

Observation of medications available for Resident #4 on 04/12/23 at 2:33pm revealed Novolog flex pen for SSI was not available for administration.

Interview with Resident #4 on 04/12/23 at 2:59pm revealed:
-He was administered insulin 3 times daily for diabetes.
-He had recently been hospitalized for high blood sugars, but he did not remember when.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/13/23 at 9:30am revealed:
-Resident #4 had an order for Novolog SSI: 151-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, 401-500= 15 units scheduled for administration at 7:30am, 11:30am, and 4:30pm.
-Resident #4's Novolog SSI was discontinued on 04/08/23.

Telephone interview with Resident #4's PCP on

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04/13/23 at 11:25am revealed:
-She started seeing residents at the facility 3 weeks ago.
-Resident #4 did not currently have orders for a sliding scale insulin, but she would be making medication changes today, 04/13/23.
-Resident #4's FSBS were "all over the place."
-She had not been notified Resident #4 received any incorrect amounts of insulin.
-She expected the facility to administer Resident #4's medication as ordered and to notify her if he was administered incorrect amounts of insulin.
-Administering more than or less than the ordered amounts of insulin per the sliding scale could result in hyperglycemia or hypoglycemia.

Telephone interview with a medication aide (MA) on 04/13/23 at 12:24pm revealed:
-The personal care aides (PCA) checked the FSBS and wrote down the FSBS result on a sheet of paper.
-The PCAs brought the documented FSBS to her, then she metered the insulin pen according to the SSI and documented the number of units on the eMAR and administered the insulin.
-She had not noticed she documented any incorrect amounts of insulin according to Resident #4's SSI.
-She always double checked the number of units of insulin that were to be administered before she administered them.

Telephone interview with a second MA on 04/13/23 at 1:55pm revealed:
-The Resident Care Director (RCD) was responsible for reviewing the insulin administration on the eMARs, but she did not know how often.
-She had not noticed any insulin administered incorrectly per the SSI for Resident #4.

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Telephone interview with the RCD on 04/13/23 at 2:55pm revealed:
-She and the MAs reviewed the eMARs for insulin administration.
-The MAs were supposed to review the eMAR every time they administered insulin and every month.
-She was not aware of any errors with Resident #4's SSI.

Attempted telephone interviews with the Administrator on 04/13/23 at 4:12pm and 4:48pm were unsuccessful.

Attempted telephone interview with the facility's Owner on 04/13/23 at 4:39pm was unsuccessful.

2. Review of Resident #2's current FL2 dated 11/16/22 revealed diagnoses included paranoid schizophrenia, hypertension, hyperlipidemia, diabetes, bipolar disorder, and anxiety.

a. Review of Resident #2's current FL2 dated 11/16/22 revealed an order for Novolog flex pen 100u/ml (a rapid-acting insulin used to lower elevated blood sugar levels), check fingerstick blood sugars (FSBS) with sliding scale insulin (SSI): if FSBS less than 150= 0 units, 151-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, 401-450= 12 units, greater than 450= call medical doctor (MD); hold if lower than 80.

Review of Resident #2's electronic Medication Administration Record (eMAR) for February 2023 revealed:
-There was an entry for Novolog flex pen 100u/ml, check fingerstick blood sugars (FSBS) before each meal with SSI in addition to meal

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D 358	Continued From page 33 coverage. If FSBS less than 150= 0 units, 151-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, 401-450= 12 units, greater than 450= call MD and scheduled for 7:30am, 11:30am, and 5:00pm; hold FSBS if lower than 80. -On 02/04/23 at 7:30am, there was documentation Resident #2's FSBS was 382 and 8 units of insulin were administered; Resident #2 should have been administered 10 units of insulin. -On 02/15/23 at 5:00pm, there was documentation Resident #2's FSBS was 112 and 8 units of insulin were administered; Resident #2 should have been administered 0 units of insulin. -On 02/21/23 at 5:00pm, there was documentation Resident #2's FSBS was 127 and 8 units of insulin were administered; Resident #2 should have been administered 0 units of insulin. -Resident #2's FSBSs ranged from 112 to 504 from 02/01/23 through 02/28/23. Review of Resident #2's eMAR for March 2023 revealed: -There was an entry for Novolog flex pen 100u/ml, check fingerstick blood sugars (FSBS) before each meal with SSI in addition to meal coverage. If FSBS less than 150= 0 units, 151-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, 401-450= 12 units, greater than 450= call medical doctor (MD) scheduled for 7:30am, 11:30am, and 5:00pm; hold if lower than 80. -On 03/18/23 at 7:30am, there was documentation Resident #2's FSBS was 316 and 6 units of insulin were administered; Resident #2 should have been administered 8 units of insulin. -On 03/25/23 at 7:30am, there was documentation Resident #2's FSBS was 292 and 4 units of insulin were administered; Resident #2	D 358		

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should have been administered 6 units of insulin.
-On 03/26/23 at 5:00pm, there was documentation Resident #2's FSBS was 151 and 0 units of insulin were administered; Resident #2 should have been administered 2 units of insulin.
-On 03/28/23 at 5:00pm, there was documentation Resident #2's FSBS was 187 and 0 units of insulin were administered; Resident #2 should have been administered 2 units of insulin.
-Resident #2's FSBSs ranged from 93 to 528 from 03/01/23 through 03/31/23.

Review of Resident #2's eMAR for from 04/01/23 through 04/11/23 revealed:
-There was an entry for Novolog flex pen 100u/ml, check fingerstick blood sugars (FSBS) before each meal with SSI in addition to meal coverage. If FSBS less than 150= 0 units, 151-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, 401-450= 12 units, greater than 450= call MD scheduled for 7:30am, 11:30am, and 5:00pm; hold if FSBS lower than 80.
-On 04/02/23 at 5:00pm, there was documentation Resident #2's FSBS was 197 and 0 units of insulin were administered; Resident #2 should have been administered 2 units of insulin.
-On 04/07/23 at 5:00pm, there was documentation Resident #2's FSBS was 194 and 4 units of insulin were administered; Resident #2 should have been administered 2 units of insulin.
-Resident #2's FSBSs ranged from 127 to 411 from 04/01/23 through 04/11/23.

Observation of medications available for administration for Resident #2 on 04/12/23 at 2:21pm revealed there were 3 pens of Novolog available for administration.

Interview with Resident #2 on 02/12/23 at 2:53pm

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revealed:
-He was administered insulin 2 to 3 times a day.
-The medication aides (MA) usually told him what his FSBS results were; sometimes his FSBS were high and sometimes they were low.
-When his FSBS were low, MAs sometimes gave him orange juice.
-He did not know what the MAs did for him when his FSBSs were high.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/13/23 at 9:30am revealed:
-Resident #2 had an order for Novolog flex pen 100u/ml, check fingerstick blood sugars (FSBS) before each meal with SSI in addition to meal coverage. If FSBS less than 150= 0 units, 151-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, 401-450= 12 units, greater than 450= call medical doctor (MD) scheduled for 7:30am, 11:30am, and 5:00pm; hold if FSBS lower than 80.
-Four pens of Novolog were dispensed to the facility on 02/28/23 and on 03/27/23.

Telephone interview with Resident #2's PCP on 04/13/23 at 11:25am revealed:
-She started seeing residents at the facility 3 weeks ago.
-She had not been notified Resident #2 was administered any incorrect amounts of insulin.
-She expected the facility to administer Resident #2's mediations as ordered and to notify her if he was administered incorrect amounts of insulin.
-Administering more than or less than the ordered amounts of insulin per the sliding scale could result in hyperglycemia or hypoglycemia.

Telephone interview with a medication aide (MA) on 04/13/23 at 12:24pm revealed:

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D 358	Continued From page 36 -The personal care aides (PCA) checked the FSBS and wrote down the FSBS results on a sheet of paper. -The PCAs brought the documented FSBS to her, then she metered the insulin pen according to the SSI and documented the number of units on the eMAR, and administered the insulin. -She had not noticed she documented any incorrect amounts of insulin according to Resident #2's SSI. -She always double checked the number of units of insulin that were to be administered before she administered them. Telephone interview with a second MA on 04/13/23 at 1:55pm revealed: -The Resident Care Director (RCD) was responsible for reviewing the insulin administration on the eMARs but she did not know how often. -She had not noticed any insulin not administered per the SSI for Resident #2. Telephone interview with the RCD on 04/13/23 at 2:55pm revealed: -She and the MAs reviewed the eMARs for insulin administration. -The MAs were supposed to review the eMAR every time they administered insulin and every month. -She was not aware of any errors in administration with Resident #2's SSI. Attempted telephone interviews with the Administrator on 04/13/23 at 4:12pm and 4:48pm were unsuccessful. Attempted telephone interview with the facility's Owner on 04/13/23 at 4:39pm was unsuccessful.	D 358		

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b. Review of Resident #2's current FL2 dated 11/16/22 revealed an order for Latuda (an antipsychotic used to treat bipolar disorder) 80mg 1 tablet every day.

Review of Resident #2's electronic Medication Administration Record (eMAR) for February 2023 revealed:
-There was an entry for Latuda 80mg 1 tablet daily scheduled for administration at 7:00am.
-There was documentation Latuda was administered for 27 of 28 days from 02/01/23 to 02/28/23.
-There was documentation Latuda was not administered on 02/27/23 due to the medication was not available.

Review of Resident #2's eMAR for March 2023 revealed:
-There was an entry for Latuda 80mg 1 tablet daily scheduled for administration at 7:00am.
-There was documentation Latuda was administered for 19 of 31 days from 03/01/23 to 03/31/23.
-There was documentation on 03/13/23 and 03/20/23 that Latuda was not administered due to the medication was not available.
-There was documentation Latuda was discontinued on 03/21/23.
-There was no documentation Latuda was administered for 10 days from 03/22/23 through 03/31/23.

Review of Resident #2's electronic eMAR for April 2023 from 04/01/23 through 04/11/23 revealed:
-There was no entry for Latuda 80mg 1 tablet daily.
-There was no documentation Latuda had been administered for 11 days from 04/01/23 through 04/11/23.

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Observation of the medications available for Resident #2 on 04/12/23 at 2:19pm revealed:
-Latuda was dispensed to the facility on 04/11/23 with a quantity of 24 tablets.
-There were 23 tablets remaining.

Interview with Resident #2 on 03/12/23 at 2:53pm revealed he knew he was administered some medications for his mental health, but he did not know which ones.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/13/23 at 9:30am revealed:
-Latuda 80mg was dispensed to the facility on 01/06/23 with a quantity of 28 tablets; Latuda should have lasted until 02/03/23 if administered daily.
-Latuda 80mg was dispensed to the facility on 02/03/23 with a quantity of 28 tablets; Latuda should have lasted until 03/03/23 if administered daily.
-Latuda 80mg was dispensed to the facility on 03/03/23 with a quantity of 28 tablets; Latuda should have lasted until 03/31/23 if administered daily.
-Latuda 80mg was discontinued by a medication aide (MA) at the facility on 03/21/23 at 8:13pm.
-The pharmacy did not have an order to discontinue Latuda.
-There was a new order for Latuda 80mg 1 tablet daily sent to the pharmacy on 04/11/23 and 24 tablets were dispensed to the facility on 04/11/23.

Interview with a MA on 04/11/23 at 4:40pm revealed:
-She discontinued Latuda from the eMAR on 03/21/23, because she thought she saw on the eMAR system that the order for Latuda was to be

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discontinued.
-She never saw a physician's order and could not find the order to discontinue Latuda.
-Another MA contacted the pharmacy on 04/11/23 to see if they had the order to discontinue Latuda and the pharmacy did not have the order.
-The Resident Care Director (RCD) contacted Resident #2's primary care provider (PCP) on 04/11/23 and found out that Latuda should not have been discontinued.
-There was a new order for Latuda received from Resident #2's Mental Health Provider (MHP) on 04/11/23 and the order was sent to the pharmacy on 04/11/23.

Interview with Resident #2's PCP on 04/13/23 at 11:25am revealed:
-Resident #2's MHP managed his Latuda.
-She did not see any orders in the system to discontinue Latuda.
-There was a triage note in the system dated 04/11/23 requesting an order for Latuda.

Interview with the RCD on 04/13/23 at 2:55pm revealed:
-A MA discontinued the order for Latuda on the eMAR system by mistake.
-The facility did not have a hard copy of a physician's order to discontinue Latuda.
-The only way Latuda could have been discontinued by staff at the facility was if the medication was tagged with a yellow flag by the pharmacy.
-She did not know the order for Latuda had been discontinued when it should not have been.

Attempted interview with Resident #2's MHP on 04/13/23 at 1:43pm was unsuccessful.

Attempted telephone interviews with the

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Administrator on 04/13/23 at 4:12pm and 4:48pm were unsuccessful.

Attempted telephone interview with the facility's Owner on 04/13/23 at 4:39pm was unsuccessful.

c. Review of Resident #2's current FL2 dated 11/16/22 revealed an order for lorazepam (used to treat anxiety) 0.5mg 1 tablet twice daily.

Review of Resident #2's electronic Medication Record (eMAR) for February 2023 revealed:
-There was an entry for lorazepam 0.5mg 1 tablet twice daily scheduled for administration at 7:00am and 6:00pm.
-There was documentation lorazepam was administered for 50 of 56 opportunities from 02/01/23 through 02/28/23.
-There was documentation lorazepam was not administered on 02/11/23 at 6:00pm due to medication was not in the facility, on 02/12/23 at 7:00am due to waiting on pharmacy, and on 02/13/23 at 6:00pm due to the MHP was contacted to write a prescription for lorazepam.
-There was a blank space with no documentation on 02/08/23 at 6:00pm, 02/15/23 at 6:00pm, and on 02/28/23 at 6:00pm.

Review of Resident #2's eMAR for March 2023 revealed:
-There was an entry for lorazepam 0.5mg 1 tablet twice daily scheduled for administration at 7:00am and 6:00pm.
-There was documentation lorazepam was administered for 59 of 62 opportunities from 03/01/23 through 03/31/23.
-There was a blank space with no documentation on 03/08/23 at 6:00pm, 03/15/23 at 6:00pm, and on 03/22/23 at 6:00pm.

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Observation of the medications available for Resident #2 on 04/12/23 at 2:19pm revealed:
-Lorazepam was dispensed to the facility on 04/07/23 with a quantity of 56 tablets.
-There were 49 tablets remaining.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/13/23 at 9:30am revealed:
-Resident #2 had an order for lorazepam 0.5mg 1 tablet twice daily.
-Lorazepam was dispensed to the facility on 01/06/23 with a quantity of 56 tablets; lorazepam should have lasted for 28 days, until 02/03/23.
-The pharmacy received an electronic prescription for lorazepam on 02/13/23 and dispensed lorazepam to the facility on 02/13/23 with a quantity of 50 tablets; lorazepam should have lasted for 25 days, until 03/10/23.
-Lorazepam was dispensed to the facility on 03/05/23 with a quantity of 56 tablets; lorazepam should have lasted 28 days, until 04/02/23.
-Lorazepam was dispensed to the facility on 03/30/23 with a quantity of 56 tablets; lorazepam should have lasted 28 days.

Interview with Resident #2 on 03/12/23 at 2:53pm revealed he knew he was administered some medications for his mental health, but he did not know which ones.

Telephone interview with a medication aide (MA) on 04/13/23 at 12:24pm revealed:
-If a medication was not available in the facility, she documented "waiting on pharmacy," or medication not available."
-If a medication was not available, she pressed the reorder button on the eMAR system and most of the time she saw the medication had already been reordered.

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-She did not contact the pharmacy via phone to see why a medication had not been delivered to the facility.
-She did not remember Resident #2 being out of lorazepam.

Telephone interview with a MA on 04/13/23 at 1:55pm revealed:
-She reordered medications when there were about 8 tablets remaining.
-She had not noticed Resident #2 was out of lorazepam in February or March 2023.

Telephone interview with the Resident Care Director (RCD) on 04/13/23 at 2:55pm revealed:
-She knew Resident #2 needed a new prescription for lorazepam in order to have it filled in February 2023.
-There should have been documentation on the eMAR regarding getting a new prescription.
-She or a MA were responsible for contacting the MHP for a new prescription.
-If there were blank spaces on the eMAR, it meant that a medication was not administered.

Interview with Resident #2's PCP on 04/13/23 at 11:25am revealed:
-Resident #2's MHP managed his lorazepam.
-She expected Resident #2's medications to be reordered and new prescriptions obtained prior to running out.
-She expected for all medications to be administered as ordered.

Attempted interview with Resident #2's MHP on 04/13/23 at 1:43pm was unsuccessful.

Attempted telephone interviews with the Administrator on 04/13/23 at 4:12pm and 4:48pm were unsuccessful.

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Attempted telephone interview with the facility's Owner on 04/13/23 at 4:39pm was unsuccessful.

3. Review of Resident #1's current FL2 dated 11/21/22 revealed diagnoses included diabetes, neurogenic bladder, neuroleptic-induced Parkinson's, and paranoid schizophrenia.

a. Review of Resident #1's current FL2 dated 11/21/22 revealed an order for semaglutide (Ozempic) (a weekly injection used to treat diabetes by controlling blood sugar levels) 1mg/0.75mL, inject 1mg subcutaneously once weekly.

Review of Resident #1's physician's orders on 04/11/23 revealed there was no order to discontinue Ozempic.

Review of Resident #1's communication report with the pharmacy dated 03/15/23 revealed:
-There was documentation that the Resident Care Director (RCD) had contacted the pharmacy to notify pharmacy staff that she had erroneously written Resident #1's name on an Ozempic order for another resident that she had faxed to the pharmacy.
-The pharmacy staff documented they would discontinue Resident #1's Ozempic order per the RCD.

Review of Resident #1's February 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Ozempic 4mg/3mL solution, inject 1mg subcutaneously once a week on Thursday, scheduled at 8:00am.
-There was documentation Ozempic was not administered on 02/02/23 due to waiting on the

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medication to be mailed to the facility, on 02/09/23 due to medication not in the facility, on 02/16/23 due to awaiting refill, and on 02/23/23 due to awaiting refill.
-Fingerstick blood sugar (FSBS) values from 02/01/23 through 02/28/23 ranged from 50 to 387.

Review of Resident #1's March 2023 eMAR revealed:
-There was an entry for Ozempic 4mg/3mL solution, inject 1mg subcutaneously once a week on Thursday, scheduled at 8:00am.
-There was documentation Ozempic was not administered on 03/02/23 due to "physically unable to take," on 03/09/23 due to needing an order for the medication, and on 03/16/23 due to awaiting prescription.
-There was documentation Ozempic was discontinued from the eMAR on 03/16/23.
-FSBS values from 03/01/23 through 03/31/23 ranged from 56 to 363.

Review of Resident #1's April 2023 eMAR from 04/01/23 through 04/11/23 revealed:
-There was no entry for Ozempic 4mg/3mL solution, inject 1mg subcutaneously once weekly.
- FSBS values from 04/01/23 through 04/11/23 ranged from 84 to 371.

Review of Resident #1's Progress Notes revealed:
-There was no documentation Resident #1's primary care provider (PCP) was notified about Resident #1 not receiving Ozempic due to the medication not being available.
-There was no documentation from the pharmacy regarding Ozempic being unavailable to send.

Review of Resident #1's laboratory work dated

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07/19/22 revealed:
-Resident #1's hemoglobin A1C value (an average estimated blood sugar for the previous three months) was 7.4% (normal reference range being 5.0-6.1%).
-There was documentation that each 1% elevation in hemoglobin A1C reflected an increase in average glucose concentration of approximately 30mg/dL.

Review of Resident #1's laboratory work dated 02/21/23 revealed that his hemoglobin A1C value was 7.6%.

Observation of medication on hand for Resident #1 on 04/12/23 at 10:25am revealed there was no Ozempic available for Resident #1.

Interview with the RCD on 04/11/23 at 2:47pm revealed:
-Resident #1 never took Ozempic because it was on backorder at the pharmacy.
-The primary care nurse and mental health social worker (MH/SW) from the Veteran's Administration (VA) came to the facility in early February 2023 and reviewed all of Resident #1's medications, and she thought the nurse was going to get a discontinue order for Resident #1's Ozempic.
-She had never received an order from Resident #1's PCP to discontinue Ozempic, but it was discontinued because of the verbal agreement with the nurse.

Telephone interview with Resident #1's MH/SW on 04/12/23 at 10:30am revealed:
-The VA managed and supplied all of Resident #1's medications.
-The VA pharmacy either mailed Resident #1's medications to the facility, or the facility was able

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to pick up medications directly from the pharmacy.
-She was not aware that Resident #1 had missed doses of any of his medications.
-She was a contact the facility could utilize to facilitate medication refills with the pharmacy, but primarily for Resident #1's mental health prescriptions because the primary care nurse assisted with refills for his other medications like Ozempic.
-Since Ozempic was ordered to help manage diabetes, possible adverse effects from not taking Ozempic as ordered included poorly controlled blood sugars.

Interview with a medication aide (MA) on 04/12/23 at 3:10pm revealed:
-She thought the MAs had administered Ozempic to Resident #1 a couple of times before the pharmacy stopped sending it.
-Resident #1's Ozempic order had been discontinued from the eMAR, but she had not seen a discontinue order so either the RCD or another MA had approved the pharmacy's removal of Ozempic from the eMAR.
-Ozempic was a medication that the MAs could administer if it was available; Resident #1 did not go to the VA to receive the Ozempic injections.

Telephone interview with a representative from the VA pharmacy on 04/12/23 at 4:00pm revealed:
-Resident #1 had a current order on file for Ozempic, inject 1mg subcutaneously once weekly.
-The pharmacy had last dispensed Ozempic for Resident #1 on 09/12/22 for a 28-day supply.
-She did not see any documented refill requests from the facility for Resident #1's Ozempic.
-There were 11 refills remaining on Resident #1's

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Ozempic prescription.
-Ozempic was not a cycle fill medication so the facility would have to contact the pharmacy to request a refill.

Interview with Resident #1 on 04/12/23 at 4:55pm revealed:
-He was supposed to get weekly injections for his diabetes, but had not been receiving them.
-He did not know why the MAs were not giving him the Ozempic injections
-He thought his blood sugars had been well controlled with his other diabetic medications, but he had been eating more unhealthy foods lately which had caused high FSBS results.

Telephone interview with a representative from the facility's contracted pharmacy on 04/13/23 at 9:30am revealed:
-The facility faxed Resident #1's medication orders to their pharmacy and they profiled the orders to maintain Resident #1's eMAR.
-Resident #1's Ozempic order had been discontinued from his profile at the pharmacy on 03/16/23 per the RCD's request and was never reactivated.

Attempted telephone interview with Resident #1's primary care nurse at the VA on 04/12/23 at 9:47am was unsuccessful.

Attempted telephone interviews with Resident #1's nurse case manager at the VA on 04/12/23 at 2:30pm and 04/13/23 at 12:15pm were unsuccessful.

Attempted telephone interview with Resident #1's PCP on 04/13/23 at 12:40pm was unsuccessful.

Attempted telephone interviews with the

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Administrator on 04/13/23 at 4:12pm and 4:48pm were unsuccessful.

Attempted telephone interview with the facility's Owner on 04/13/23 at 4:39pm was unsuccessful.

b. Review of Resident #1's physician's order dated 12/08/22 revealed an order for fluvoxamine (an antidepressant used to treat obsessive-compulsive disorder (OCD)) 100mg three times daily.

Review of Resident #1's February 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for fluvoxamine 100mg three times daily scheduled at 8:00am, 2:00pm and 8:00pm.
-There was documentation fluvoxamine was not administered at 2:00pm on 02/05/23 with the reason documented as "physically unable to take."

Review of Resident #1's March 2023 eMAR revealed:
-There was an entry for fluvoxamine 100mg three times daily scheduled at 8:00am, 2:00pm and 8:00pm.
-There was documentation fluvoxamine was not administered 14 times from 03/01/23 through 03/31/23 with the reasons documented as "physically unable to take" due to awaiting delivery from the pharmacy 9 times, refused 3 times, and "out of the facility" 2 times.

Review of Resident #1's April 2023 eMAR from 04/01/23 through 04/11/23 revealed:
-There was an entry for fluvoxamine 100mg three times daily scheduled at 8:00am, 2:00pm and 8:00pm.

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-There was no documentation fluvoxamine was administered at 2:00pm on 04/08/23 or at 8:00am on 04/09/23 and no documented reason why.

Review of Resident #1's psychiatric progress note dated 03/22/23 revealed:
-Resident #1 had a diagnosis of OCD.
-Resident #1 was ordered fluvoxamine 100mg three times daily to help treat and manage OCD.
-Staff had reported to her that Resident #1 was doing well and had no changes to his mood.

Observation of medications on hand for Resident #1 on 04/12/23 at 10:25am revealed:
-There was one large bottle of fluvoxamine 100mg tablets with a dispensed date of 03/22/23 with a quantity of 270 tablets dispensed.
-The bottle was over half full of tablets remaining.

Interview with Resident #1 on 04/11/23 at 3:30pm revealed:
-He did not know if he had missed doses of fluvoxamine.
-He was familiar with some of his medications, but he received so many medications that he just took whichever pills were in his medication cup and he did not count them.
-He did not remember feeling any differently or experiencing new symptoms in the last three months.

Telephone interview with Resident #1's mental health social worker (MH/SW) at the Veteran's Administration (VA) on 04/12/23 at 10:30am revealed:
-Resident #1 took fluvoxamine for OCD compulsions related to delusions about other people talking about him, and paranoia.
-Resident #1 should not have missed taking 14 doses of fluvoxamine in one month as he did in

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March 2023.
-Possible adverse effects from missing so many doses of fluvoxamine in one month could include an increase in paranoia which could lead to other behaviors.
-She would expect the facility to administer Resident #1's mental health medications as they were ordered or to contact her if they had any trouble obtaining the medication from the pharmacy.

Interview with a medication aide (MA) on 04/12/23 at 3:10pm revealed:
-She had documented Resident #1 being out of fluvoxamine on 03/15/23.
-She did not remember Resident #1 being out of fluvoxamine.
-She had not called the pharmacy to request a refill of fluvoxamine because the Resident Care Director (RCD) had taken responsibility for contacting the VA for refills or updates to the doctor.
-She could not remember if she had told the RCD that Resident #1 needed a refill of fluvoxamine.
-Resident #1 had not displayed any compulsive behaviors or increased paranoia in the previous three months.

Telephone interview with a representative from the VA pharmacy on 04/12/23 at 4:00pm revealed:
-Resident #1 had a current order for fluvoxamine 100mg three times daily.
-Fluvoxamine had been dispensed to the facility on 02/03/23 for 90 tablets which was a 30-day supply.
-Fluvoxamine had last been dispensed to the facility on 03/22/23 for 270 tablets which was a 90-day supply.
-The VA pharmacy usually mailed medication to

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the facility for Resident #1 and delivery of a medication after a refill was requested, it could take up to 10 days.

Telephone interview with a MA on 04/13/23 at 12:50pm revealed:
-She had documented Resident #1's fluvoxamine as not administered on 02/21/23, and the reason was "out of the facility" so Resident #1 had likely been at an appointment.
-She did not remember Resident #1 being out of fluvoxamine for a period of time in March 2023.
-Resident #1 kept to himself and never had behavioral issues.
-She had not observed Resident #1 experiencing symptoms of increased paranoia or OCD compulsions in the last three months.

Telephone interview with a second MA on 04/13/23 at 1:30pm revealed:
-She had documented Resident #1's fluvoxamine as not administered 13 times in March 2023.
-She had noticed Resident #1 being out of fluvoxamine during a medication cart audit the first week of March 2023 and she let the RCD know.
-She had not observed Resident #1 experiencing symptoms of increased paranoia or OCD compulsions in the last three months.

Telephone interview with the RCD on 04/13/23 at 2:45pm revealed:
-When a medication was running low for Resident #1, either she or one of the MAs would call the VA pharmacy and request a refill.
-The VA was slow to respond, so once they made a refill request there was nothing else they could do besides wait for the medication to be delivered.
-She would not comment further on Resident #1's

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medications.

Attempted telephone interviews with Resident #1's nurse case manager at the VA on 04/12/23 at 2:30pm and 04/13/23 at 12:15pm were unsuccessful.

Attempted telephone interview with Resident #1's PCP on 04/13/23 at 12:40pm was unsuccessful.

Attempted telephone interviews with the Administrator on 04/13/23 at 4:12pm and 4:48pm were unsuccessful.

Attempted telephone interview with the facility's Owner on 04/13/23 at 4:39pm was unsuccessful.

c. Review of Resident #1's physician's order dated 08/25/22 revealed an order to take ibuprofen (an over-the-counter medication used to treat pain) 600mg every 8 hours for pain.

Review of Resident #1's physician's order dated 03/15/23 revealed:
-There was an order for Flexeril (a muscle relaxer used to treat muscle spasms) 10mg twice daily for 10 days.
-There was an order to hold ibuprofen for 10 days, but there was no indication for the hold documented.

Review of Resident #1's March 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for ibuprofen 600mg take 1 tablet every 8 hours for pain scheduled at 8:00am, 2:00pm and 8:00pm.
-There was an entry for Flexeril 10mg twice daily scheduled at 8:00am and 8:00pm with a start date of 03/16/23 and an end date of 03/26/23.

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-There was documentation ibuprofen was administered at 8:00am, 2:00pm, and 8:00pm from 03/17/23 through 03/26/23.
-There was documentation Flexeril 10mg was administered at 8:00am and 8:00pm from 03/17/23 through 03/26/23.

Interview with a medication aide (MA) on 04/12/23 at 3:10pm revealed:
-She was not aware that Resident #1 had an order to hold ibuprofen from 03/17/23 through 03/26/23.
-Resident #1's ibuprofen had never been held on his eMAR, so she had administered the ibuprofen as she thought it was ordered.
-Whichever staff person, either the MA or Resident Care Director (RCD), had faxed the order to the pharmacy should have noticed that the ibuprofen order had not been held when they were approving the Flexeril entry on the eMAR.
-The MA also could have entered a hold on the ibuprofen entry in the eMAR system so that the other MAs did not administer it.

Telephone interview with a representative from the Veteran's Administration (VA) pharmacy on 04/12/23 at 4:00pm revealed:
-Resident #1 had an order for Flexeril dated 03/15/23 and had been dispensed a 10-day supply of the medication.
-She did not see the order to hold ibuprofen in Resident #1's medication profile at the pharmacy.

Interview with Resident #1 on 04/11/23 at 3:30pm revealed:
-He was familiar with some of his medications, but he received so many medications that he just took whichever pills were in his medication cup and he did not count them.
-He did not remember feeling any differently or

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experiencing new symptoms in the last three months.

Telephone interview with the RCD on 04/13/23 at 2:45pm revealed:
-She was not aware that Resident #1 had an order to hold ibuprofen for 10 days in March 2023.
-She was responsible for auditing the eMARs and physician's orders to ensure medications were administered as ordered.
-She would not comment further on Resident #1's medications.

Attempted telephone interview with Resident #1's primary care nurse at the VA on 04/12/23 at 9:47am was unsuccessful.

Attempted telephone interviews with Resident #1's nurse case manager at the VA on 04/12/23 at 2:30pm and 04/13/23 at 12:15pm were unsuccessful.

Attempted telephone interview with Resident #1's PCP on 04/13/23 at 12:40pm was unsuccessful.

Attempted telephone interviews with the Administrator on 04/13/23 at 4:12pm and 4:48pm were unsuccessful.

Attempted telephone interview with the facility's Owner on 04/13/23 at 4:39pm was unsuccessful.

d. Review of Resident #1's physician's order dated 09/02/22 revealed an order for fluticasone (a steroid nasal spray used to treat symptoms such as sneezing, runny or stuffy nose) 50mcg nasal spray, instill 1 spray in each nostril twice daily.

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Review of Resident #1's February 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for fluticasone 50mcg nasal spray, instill 1 spray in each nostril twice daily scheduled at 8:00am and 8:00pm.
-There was documentation fluticasone nasal spray was not administered 8 out of 56 opportunities from 02/01/23 through 02/28/23 at 8:00am on 02/08/23 through 02/12/23, 02/14/23, 02/15/23, and 02/20/23.
-The documented reason for not administering fluticasone was "physically unable to take" with an additional note for 4 of the 8 doses not administered that the medication was not available in the facility to administer.

Review of Resident #1's March 2023 eMAR revealed:
-There was an entry for fluticasone 50mcg nasal spray, instill 1 spray in each nostril twice daily scheduled at 8:00am and 8:00pm.
-There was documentation fluticasone nasal spray was not administered 6 out of 62 opportunities from 03/01/23 through 03/31/23 at 8:00am on 03/01/23 and 03/17/23, and at 8:00pm on 03/05/23, 03/06/23, 03/09/23 and 03/18/23.
-The documented reason for not administering fluticasone was "physically unable to take" with an additional note for 3 out of the 6 doses not administered that the medication was not available in the facility to administer.

Review of Resident #1's April 2023 eMAR from 04/01/23 through 04/11/23 revealed:
-There was an entry for fluticasone 50mcg nasal spray, instill 1 spray in each nostril twice daily scheduled at 8:00am and 8:00pm.
-There was documentation fluticasone nasal spray was not administered at 8:00am on

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04/09/23.
-There was no documented reason for not administering fluticasone.

Observation of medications on hand for Resident #1 on 04/12/23 at 10:25am revealed there was one bottle of fluticasone 50mcg nasal spray with a dispensed date of 03/17/23 that was half full.

Interview with Resident #1 on 04/11/23 at 3:30pm revealed:
-He had gone a period of time without being able to use his nasal spray in the last month or two because he was told they were waiting on the pharmacy to send it.
-When he was without his nasal spray, he experienced symptoms of a runny and stuffy nose.

Interview with a medication aide (MA) on 04/12/23 at 3:10pm revealed:
-She remembered not having fluticasone nasal spray available to administer to Resident #1, but could not remember the reason why it was not available.
-The Veteran's Administration (VA) pharmacy was often slow to send refills of medications, so they had probably been waiting on the pharmacy to deliver the medication.
-She had not observed Resident #1 having side effects from missing doses of fluticasone, because he took other medication to manage allergy symptoms.
-She could not remember if she had requested the refill for Resident #1's fluticasone, and the MAs were supposed to send refill requests at least 10 days prior to a medication running out.

Telephone interview with a representative from the VA pharmacy on 04/12/23 at 4:00pm

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revealed:
-Resident #1 had a current order for fluticasone 50mcg nasal spray.
-Fluticasone had last been dispensed for Resident #1 on 03/17/23 for 1 bottle of nasal spray which would be considered a one-month supply.
-Prior to the fluticasone dispensed on 03/17/23, they had last dispensed fluticasone for Resident #1 on 10/06/22.
-Fluticasone was not on an automatic cycle fill, so the facility would need to call the pharmacy to request the refill.

Telephone interview with a representative from the facility's contracted pharmacy on 04/13/23 at 9:30am revealed:
-They had dispensed fluticasone for Resident #1 in August 2022 and had not dispensed fluticasone for Resident #1 since.
-They had not received a refill request for Resident #1's fluticasone.

Telephone interview with a MA on 04/13/23 at 12:50pm revealed:
-Resident #1 had been out of fluticasone for some days during the previous week or two.
-She did not request a refill for Resident #1's fluticasone, because she was still new to the facility and did not work day shift when most of the refill request phone calls were made.
-She could not remember if she had notified the Resident Care Director (RCD) that Resident #1's fluticasone needed to be refilled.
-The MAs were expected to request medication refills once they were more than halfway gone.
-The MAs were supposed to either let the RCD know that a refill request was needed or call the VA pharmacy to request the refill themselves.
-After a medication refill was requested from the

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VA pharmacy, they usually mailed the medication to the facility within a couple of days.
-She had not observed Resident #1 having allergy symptoms while he was out of fluticasone.

Telephone interview with a second MA on 04/13/23 at 1:30pm revealed:
-She documented Resident #1's fluticasone as not administered 5 times in March 2023.
-She noticed Resident #1 was out of fluticasone during a medication cart audit and she let the RCD know.
-She had not observed Resident #1 experiencing symptoms of allergies or nasal congestion when he was out of fluticasone.

Telephone interview with the RCD on 04/13/23 at 2:45pm revealed:
-She was aware Resident #1 had been out of fluticasone.
-When Resident #1 switched all his medications to the VA pharmacy in February 2023, the nurse from the VA had gone to the facility to review all of Resident #1's medications and the orders were sent to the VA pharmacy.
-She did not remember when a refill request for Resident #1's fluticasone had been sent to the VA pharmacy.
-She would not comment further on Resident #1's medications.

Attempted telephone interview with Resident #1's primary care nurse at the VA on 04/12/23 at 9:47am was unsuccessful.

Attempted telephone interviews with Resident #1's nurse case manager at the VA on 04/12/23 at 2:30pm and 04/13/23 at 12:15pm were unsuccessful.

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Attempted telephone interview with Resident #1's PCP on 04/13/23 at 12:40pm was unsuccessful.

Attempted telephone interviews with the Administrator on 04/13/23 at 4:12pm and 4:48pm were unsuccessful.

Attempted telephone interview with the facility's Owner on 04/13/23 at 4:39pm was unsuccessful.

e. Review of Resident #1's physician's order dated 09/07/22 revealed an order for melatonin (a supplement used for sleep) 10mg every night at bedtime.

Review of Resident #1's February 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for melatonin 10mg at bedtime scheduled at 8:00pm.
-There was documentation melatonin was not administered 5 times from 02/01/23 through 02/28/23 on 02/11/23, 02/14/23, 02/15/23, 02/21/23, and 02/28/23.
-The documented reason melatonin was not administered was that the medication was not available in the facility.

Review of Resident #1's March 2023 eMAR revealed:
-There was an entry for melatonin 10mg at bedtime scheduled at 8:00pm.
-There was documentation melatonin was not administered 6 times from 03/01/23 through 03/31/23 on 03/05/23, 03/06/23, 03/08/23, 03/18/23 and 03/20/23.
-The reason melatonin was not administered was documented as "physically unable to take" or waiting on delivery from the pharmacy.

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Review of Resident #1's April 2023 eMAR from 04/01/23 through 04/11/23 revealed:
-There was an entry for melatonin 10mg at bedtime scheduled at 8:00pm.
-There was documentation melatonin was not administered 2 times on 04/05/23 and 04/06/23.
-The reason melatonin was not administered was documented as "waiting on delivery from the pharmacy".

Review of Resident #1's psychiatric progress note dated 03/22/23 revealed:
-Resident #1 had a diagnosis of insomnia disorder related to another mental disorder.
-Staff had reported to her that Resident #1 was doing well and his sleeping habits were stable.
-She was prescribing Resident #1 melatonin 10mg for sleep along with another sleep aid and Resident #1 was stable with that medication regimen.

Observation of medications on hand for Resident #1 on 04/12/23 at 10:25am revealed there was no melatonin available for administration.

Telephone interview with Resident #1's mental health social worker (MHSW) on 04/12/23 at 10:30am revealed:
-The Veteran's Administration (VA) managed and supplied all of Resident #1's medications.
-The VA pharmacy either mailed Resident #1's medications to the facility, or the facility was able to pick up medications directly from the pharmacy.
-She was not aware that Resident #1 had missed doses of any of his melatonin.
-She was a contact at the VA that the facility could utilize to facilitate medication refills with the pharmacy.
-There was no risk of side effects from missing

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doses of melatonin other than poor sleep.

Telephone interview with a representative from the VA pharmacy on 04/12/23 at 4:00pm revealed:
-The pharmacy did not have a current order for melatonin for Resident #1.
-They had received an order for melatonin on 09/10/22 and then the order had been discontinued on 09/14/22.

Interview with Resident #1 on 04/12/23 at 4:55pm revealed:
-He remembered a few nights where he did not receive melatonin.
-He always had trouble sleeping because he was on a toileting schedule and the staff woke him up every night.
-He took melatonin because he had a hard time falling asleep at night and it was worse on the nights when he did not take melatonin.

Telephone interview with a representative from the facility's contracted pharmacy on 04/13/23 at 9:30am revealed:
-The pharmacy had a current order on Resident #1's profile for melatonin 10mg at bedtime.
-Melatonin was dispensed for Resident #1 on 09/08/22 for 15 capsules.
-They had dispensed melatonin for Resident #1 on 09/16/22 and on 10/14/22 for 28 capsules, but the medication had been returned to the pharmacy both times.

Telephone interview with a medication aide (MA) on 04/13/23 at 12:50pm revealed:
-She had documented Resident #1's melatonin was not administered 5 times in February, 2 times in March and once in April 2023.
-If the medication was not available to administer,

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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
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she either documented that the resident was physically unable to take, or that she was awaiting the medication to arrive from the pharmacy.
-She had told the RCD that Resident #1 did not have melatonin after she did a medication cart audit during the first week of March 2023.
-She thought the VA had told the RCD they were not able to dispense Resident #1's melatonin until May or June 2023, but she did not know why there would be such a long wait.
-She did not know if Resident #1 had trouble sleeping on the nights he did not receive melatonin.

Telephone interview with a second MA on 04/13/23 at 1:30pm revealed:
-She had documented Resident #1's melatonin was not administered 3 times in March and once in April 2023.
-She did not remember Resident #1 ever having melatonin available on the medication cart.
-She thought the RCD had requested the melatonin refill from the VA.
-She thought someone had told her that Resident #1 would not have melatonin until after he renewed his prescription at his doctor appointment in May 2023.
-Once a prescription refill was requested from the VA pharmacy, the pharmacy usually mailed the prescription to the facility within 10 days.

Telephone interview with the RCD on 04/13/23 at 2:45pm revealed:
-She was aware of Resident #1 being out of melatonin.
-She would not comment further on Resident #1's medications.

Attempted telephone interviews with Resident #1's nurse case manager at the VA on 04/12/23

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	HAL080032	A. BUILDING: ______ B. WING ______	R 04/13/2023

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D 358	Continued From page 63 at 2:30pm and 04/13/23 at 12:15pm were unsuccessful. Attempted telephone interview with Resident #1's PCP on 04/13/23 at 12:40pm was unsuccessful. Attempted telephone interviews with the Administrator on 04/13/23 at 4:12pm and 4:48pm were unsuccessful. Attempted telephone interview with the facility's Owner on 04/13/23 at 4:39pm was unsuccessful. _______________ The facility failed to ensure medications were administered as ordered for three residents related to a resident, who had a history of diabetes and had a kidney and pancreas transplant, being administered incorrect amounts of insulin per sliding scale 14 times from 02/01/23 to 04/05/23, resulting in the resident experiencing hypoglycemia and hyperglycemia episodes with FSBS ranging from 40 to 586 between 02/01/23 and 02/28/23; 37 to 599 between 03/01/23 and 03/31/23; and 48 to 499 between 04/01/23 and 04/05/23, and was hospitalized 3 times between February and April 2023 with diagnoses including diabetic ketoacidosis, uncontrolled type 1 diabetes, and hyperglycemia (#4); a resident who was administered incorrect amounts of insulin per sliding scale 9 times from 02/01/23 to 04/11/23 with FSBS ranging from 112 to 504 between 02/01/23 and 02/28/23; 93 to 528 between 03/01/23 and 03/31/23; and 127 to 411 between 04/01/23 and 04/11/23 placing the resident at risk for hypoglycemia and hyperglycemia (#2); and a resident with orders for a weekly injectable diabetic medication that was not administered 7 times from 02/02/23 through 03/16/23 and discontinued without an order which placed the resident at risk for uncontrolled FSBS; a	D 358		

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D 358	Continued From page 64 medication used to treat obsessive-compulsions and paranoia that was not administered 14 times in March 2023 which placed the resident at risk for increased paranoia leading to other behaviors; a nasal spray that was not administered 15 times from February 2023 to April 2023 which resulted in the resident experiencing a runny nose and nasal congestion, and a medication to help with sleep which was not administered 13 times from February 2023 through April 2023 which resulted in the resident having nights with poor sleep (#1). This failure resulted in serious physical harm and neglect, which constitutes a A1 Violation. _______________ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on April 11, 2023 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 13, 2023.	D 358		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of a controlled medication for 1 of 3 sampled	D 392		

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residents (#4) related to an anti-anxiety medication.

The findings are:

Review of Resident #4's current FL2 dated 04/08/23 revealed:
-Diagnoses included schizophrenia.
-There was an order for Lorazepam 0.5mg (a Scheduled IV controlled substance used to treat anxiety and sleep problems) 1 tablet twice daily as needed.

Review of Resident #4's previous FL2 dated 02/27/23 revealed an order for Lorazepam 0.5mg 1 tablet daily.

Review of Resident #4's physician's orders dated 03/29/23 revealed an order to discontinue Ativan 0.5mg 1 tablet daily and start Lorazepam 0.5mg 1 tablet twice daily as needed.

Review of Resident #4's electronic Medication Administration Record (eMAR) for March 2023 revealed:
-There was an entry for lorazepam 0.5mg 1 tablet daily scheduled for administration at 8:00am.
-There was documentation lorazepam was administered for 26 of 29 opportunities from 03/01/23 to 03/29/23.
-There was documentation Resident #4 was out of the facility from 03/01/23 through 03/03/23.
-There was an entry for lorazepam 0.5mg 1 tablet twice daily as needed.
-There was no documentation lorazepam as needed was administered from 03/29/23 through 0/31/23

Review of the facility's controlled substance count sheets (CSCS) for March 2023 revealed:

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-There was a CSCS for Resident #4's lorazepam 0.5mg 1 tablet daily to document disposition of lorazepam between 03/04/23 and 03/18/23, but there was no CSCS to document disposition of lorazepam between 03/19/23 and 03/29/23.

Observation of Resident #4's medications available for administration on 04/12/23 at 2:31pm revealed there were two bubble packs of lorazepam 0.5mg 1 tablet twice daily dispensed to the facility on 03/29/23 with a quantity of 30 tablets and there were 27 tablets remaining.

Interview with Resident #4 on 04/12/23 at 2:53pm revealed he did not know anything about his order for lorazepam.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 04/13/23 revealed:
-Resident #4 had a current order dated 03/29/23 for lorazepam 0.5mg 1 tablet daily as needed.
-Resident #4 had a previous order for lorazepam 0.5mg 1 tablet daily.
-Lorazepam was dispensed to the facility on 02/23/23 with a quantity of 15 tablets, 03/07/23 with a quantity of 28 tablets and on 03/29/23 with a quantity of 30 tablets.
-CSCSs were sent out to the facility with each refill of lorazepam.

Telephone interview with a medication aide (MA) on 04/13/23 at 12:24pm revealed:
-She always documented administration of lorazepam on the eMAR and on the CSCS.
-She thought the CSCS went into a stack to be filed, but she was told on 04/12/23 that the CSCS had to go under the Resident Care Director's door.

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D 392	Continued From page 67 Telephone interview with a second MA on 04/13/23 at 1:55pm revealed: -MAs were to document administration of controlled substances on the eMAR and on the CSCS. -Completed CSCS were placed in the resident's record. -She was not aware of any missing CSCS for Resident #4. Telephone interview with the RCD on 04/13/23 at 2:55pm revealed: -MAs were to document on the CSCS in addition to the eMAR when a controlled substance was administered to a resident. -MAs were to give her the CSCSs once they were completed (all medication had been administered) and she kept the CSCS in her office. -Third shift MAs were responsible for filing the CSCS in the resident's record. -She was not aware Resident #4 was missing the CSCS to document disposition of lorazepam for 03/19/23 through 03/29/23. Attempted telephone interviews with the Administrator on 04/13/23 at 4:12pm and 4:48pm were unsuccessful. Attempted telephone interview with the facility's Owner on 04/13/23 at 4:39pm was unsuccessful.	D 392		