STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R 06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Edgecombe County Department of Social Services conducted a follow-up survey and complaint investigation on May 31, 2023 to June 1, 2023. The compliant investigations were initiated by the Edgecombe County Department of Social Services on April 11, 2023, May 2, 2023, May 16, 2023, and May 23, 2023.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews the facility failed to ensure follow-up to meet the acute health care needs of 4 of 5 sampled residents (#2, #5, #11, #13) related to failing to inform the primary care provider (PCP) of a toxic level of seizure medication (#2), failing to inform the PCP of multiple refusals of insulin (#5), failing to notify the PCP a resident was out of a medication used to treat anxiety (#13), and failing to report fingerstick blood sugars (FSBS) and blood pressures (BP) that were outside of parameters (#11). The findings are: 1. Review of Resident #2's current FL-2 dated 05/15/22 revealed: -Diagnoses included hypertension, metabolic encephalopathy (chemical imbalance in the blood that affects the brain), acute kidney failure, and	D 273		

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major depressive disorder.
-There was an order for Tegretol 200mg take 2 tablets 3 times a day (According to manufacturer's instructions Tegretol is used to treat certain types of seizures and certain types of nerve pain. Periodic laboratory (lab) testing should be done to monitor for drug toxicity.)

Review of Resident #2's emergency department (ED) note dated 03/09/23 revealed:
-Resident #2 was brought into the ED by Emergency Management Services (EMS) due to vomiting.
-Resident #2 was able to communicate but was lethargic.
-A Tegretol level was performed on Resident #2 with a value of 20.0 ug/mL (A therapeutic Tegretol value is 4.0 to 10.0 ug/mL).
-Resident #2 was diagnosed with nausea and vomiting and a right renal mass.
-Resident #2 was discharged on 03/10/23 with instructions to stop Tegretol for 3 days and then resume and recheck Tegretol level in 1 week.

Review of Resident #2's ED note dated 03/14/23 revealed:
-Resident #2 was brought in by EMS due to having a seizure.
-A Tegretol level was performed on Resident #2 with a value of 16.1 ug/mL.
-A report was called to staff at the facility.
-It was confirmed with facility staff that Resident #2 had "continued to receive Tegretol after being seen on the 9th with a critical level of 20 and instructed to hold Tegretol for 3 days then resume with new blood work".
-The facility staff was educated on Tegretol toxicity levels and toxicity outcomes.
-New Tegretol levels remained "critical at 16" and the ED provider ordered to hold Tegretol for 2

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days.
-When speaking to facility staff the ED nurse "stressed that these instructions must be followed, otherwise the patient could end up severely harmed or it could result in her death".
-Resident #2 was discharged to the facility on 03/14/23 at 11:01pm.

Interview with the Administrator on 05/31/23 at 2:02pm revealed:
-When the facility received new orders for a resident the MA that received the orders processed the orders.
-If new orders were received after a resident returned from the hospital the new orders were faxed to the resident's pharmacy as well as the resident's primary care provider (PCP).
-The hospital orders were faxed to resident's PCPs so the PCPs would be aware of any issues with the resident or any new orders.

Interview with Resident #2's PCP on 06/01/23 at 4:32pm revealed:
-The facility made her aware that Resident #2 was sent to the ED on 03/09/23 because she was vomiting.
-She was also made aware by the facility that Resident #2 was sent to the ED on 03/14/23 because she had a seizure.
-She was made aware by the facility that they found a mass in her brain at the ED visit on 03/09/23.
-She was not made aware by the facility that Resident #2's Tegretol level was elevated at the ED on 03/09/23 or and that her Tegretol was to be held or that her Tegretol levels needed to be rechecked.
-She expected the facility to make her aware of any new issues that were identified for Resident #2 at the ED or any new orders that were

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received for the resident.
-Resident #2's Tegretol was at a toxic level when she was seen in the ED, and it was important that the facility notify her of that so she could monitor the resident more closely and make sure her Tegretol level had come down to a therapeutic level.

2. Review of Resident #5's current FL-2 dated 02/13/23 revealed:
-Diagnoses included insulin dependent type 2 diabetes.
-There was an order for insulin glargine (a long-acting insulin used to treat high blood sugars) inject 30 units at bedtime.

Review of Resident #5's physician order sheet dated 02/16/23 revealed there was an order for insulin lispro (a short-acting insulin used to treat high blood sugars) inject four times a day before meals and at bedtime per sliding scale: 155-184 - 1 unit; 185-214 = 2 units; 215-244 = 3 units; 245-274 = 4 units.

Review of Resident #5's physician order sheet dated 03/15/23 revealed:
-There was an order for insulin lispro four times a day before meals and at bedtime per sliding scale: 155-184 inject 1 unit; 185-214 inject 2 units; 215-244 inject 3 units; 245-274 inject 4 units; 275-304 inject 5 units; 305-334 inject 6 units; 335-364 inject 7 units; over 365 inject 8 units.
-There was an order for insulin lispro inject 5 units 4 times a day before meals and at bedtime.

Review of Resident #5's March 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for insulin lispro inject 5 units

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D 273	Continued From page 4 4 times a day before meals and at bedtime with a start date of 03/16/23 scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -Insulin lispro 5 units was documented as refused on 03/19/23 at 12:00pm and 8:00pm, 03/22/23 at 12:00pm, 03/23/23 at 8:00pm, and 03/27/23 at 8:00am. -There was an entry for insulin lispro inject 4 times a day before meals and at bedtime per sliding scale: 155-184 = 1 unit; 185-214 = 2 units; 215-244 = 3 units; 245-274 = 4 units scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -Insulin lispro sliding scale was documented as refused on 03/03/23 at 8:00pm, 03/04/23 at 4:00pm, 03/09/23 at 4:00pm, and 03/10/23 at 8:00pm for fingerstick blood sugars (FSBS) greater than or equal to 155. -There was an entry for insulin lispro use as directed per sliding scale if FSBS 155-184 = 1 unit; 185-214 = 2 units; 215-244 = 3 units; 245-274 = 4 units; 275-304 = 5 units; 305-334 = 6 units; 335-364 = 7 units; over 365 = 8 units with a start date of 03/16/23 scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -Insulin lispro sliding scale was documented as refused on 03/19/23 at 4:00pm and 8:00pm, 03/22/23 at 12:00pm, 03/23/23 at 8:00pm, and 03/27/23 at 4:00pm for a FSBS greater than or equal to 155. -There was an entry for insulin glargine inject 30 units at bedtime scheduled for administration at 8:00pm. -Insulin glargine 30 units was documented as refused on 03/23/23. -Resident #5's FSBSs ranged from 88 to 369 in March 2023.	D 273		

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D 273	Continued From page 5 Review of Resident #5's April 2023 eMAR revealed: -There was an entry for insulin lispro inject 5 units 4 times a day before meals and at bedtime scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -Insulin lispro 5 units was documented as refused on 04/02/23 at 8:00am, 04/05/23 at 12:00pm, 04/07/23 at 8:00am, 04/08/23 at 12:00pm, 04/09/23 at 12:00pm, 04/11/23 at 12:00pm, 04/13/23 at 12:00pm and 4:00pm, 04/14/23 at 12:00pm, 04/17/23 at 8:00am, 04/18/23 at 4:00pm and 8:00pm, 04/19/23 at 4:00pm and 8:00pm, 04/20/23 at 4:00pm and 8:00pm, 04/21/23 at 8:00pm, 04/24/23 at 4:00pm, 04/25/23 at 4:00pm, 04/26/23 at 4:00pm and 8:00pm, 04/28/23 at 12:00pm and 8:00pm, 04/29/23 at 8:00pm, and 04/30/23 at 8:00am and 12:00pm. -There was an entry for insulin lispro use as directed per sliding scale if FSBS 155-184 = 1 unit; 185-214 = 2 units; 215-244 = 3 units; 245-274 = 4 units; 275-304 = 5 units; 305-334 = 6 units; 335-364 = 7 units; over 365 = 8 units scheduled for administration at 8:00am, 12:00pm. 4:00pm, and 8:00pm. -Insulin lispro sliding scale was documented as refused on 04/02/23 at 8:00am, 04/05/23 at 12:00pm, 04/08/23 at 12:00pm, 04/09/23 at 12:00pm, 04/11/23 at 12:00pm, 04/13/23 at 12:00pm and 4:00pm, 04/14/23 at 12:00pm, 04/19/23 at 4:00pm, 04/26/23 at 12:00pm, and 04/28/23 at 12:00pm for a FSBS greater than or equal to 155. -There was an entry for insulin glargine inject 30 units at bedtime scheduled for administration at 8:00pm. -Insulin glargine was documented as refused on 04/20/23 and 04/28/23. -Resident #5's FSBSs ranged from 88 to 445 in	D 273		

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D 273	Continued From page 6 April 2023. Review of Resident #5's May 2023 eMAR revealed: -There was an entry for insulin lispro inject 5 units 4 times a day before meals and at bedtime scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -Insulin lispro 5 units was documented as refused 05/01/23 at 8:00pm, 05/02/23 at 12:00pm and 4:00pm, 05/03/23 at 12:00pm and 8:00pm, 05/04/23 at 12:00pm and 8:00pm, 05/05/23 at 12:00pm and 4:00pm, 05/07/23 at 12:00pm and 8:00pm, 05/09/23 at 12:00pm, 4:00pm, and 8:00pm, 05/10/23 at 8:00pm, 05/11/23 at 8:00pm, 05/12/23 at 4:00pm and 8:00pm, 05/13/23 at 8:00pm, 05/15/23 at 8:00pm, 05/16/23 at 12:00pm, 4:00pm, and 8:00pm, 05/17/23 at 12:00pm, 4:00pm, and 8:00pm, 05/18/23 at 12:00pm and 8:00pm, 05/19/23 at 12:00pm, 05/20/23 at 12:00pm, 05/21/23 at 8:00am, 05/22/23 at 12:00pm and 8:00pm, 05/23/23 at 4:00pm, 05/25/23 at 12:00pm and 8:00pm, 05/26/23 at 12:00pm and 8:00pm, 05/27/23 at 8:00am, 05/28/23 at 4:00pm and 8:00pm, 05/29/23 at 12:00pm and 4:00pm, and 05/30/23 at 8:00am and 4:00pm. -There was an entry for insulin lispro use as directed per sliding scale if FSBS 155-184 = 1 unit; 185-214 = 2 units; 215-244 = 3 units; 245-274 = 4 units; 275-304 = 5 units; 305-334 = 6 units; 335-364 = 7 units; over 365 = 8 units scheduled for administration at 8:00am, 12:00pm. 4:00pm, and 8:00pm. -Insulin lispro sliding scale was documented as refused 05/01/23 at 8:00pm, 05/02/23 at 12:00pm, 05/03/23 at 12:00pm 4:00pm, and 8:00pm, 05/04/23 at 12:00pm and 4:00pm, 05/05/23 at 8:00am, 12:00pm, and 8:00pm, 05/06/23 at 4:00pm and 8:00pm, 05/07/23 at	D 273		

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D 273	Continued From page 7 12:00pm, 05/08/23 at 8:00pm, 05/09/23 at 12:00pm, 4:00pm, and 8:00pm, 05/10/23 at 8:00am and 8:00pm, 05/11/23 at 4:00pm, 05/13/23 at 8:00am, 12:00pm, 4:00pm, and 8:00pm, 05/14/23 at 8:00am, 12:00pm, and 4:00pm, 05/15/23 at 8:00pm, 05/16/23 at 12:00pm, 4:00pm, and 8:00pm, 05/17/23 at 12:00pm, 4:00pm, and 8:00pm, 05/18/12 at 12:00pm, 05/19/23 at 12:00pm and 8:00pm, 05/20/23 at 12:00pm, and 4:00pm, 05/21/23 at 8:00am, 05/22/23 at 12:00pm and 4:00pm, 05/23/23 at 4:00pm, 05/24/23 at 8:00am and 12:00pm, and 8:00pm, 05/25/23 at 12:00pm and 8:00pm, 05/26/23 at 12:00pm, 4:00pm, and 8:00pm, 05/27/23 at 4:00pm and 8:00pm, 05/28/23 at 12:00pm, 4:00pm, and 8:00pm, 05/29/23 at 12:00pm, 4:00pm, and 8:00pm, and 05/30/23 at 8:00am and 4:00pm for a FSBS greater than or equal to 155. -There was an entry for insulin glargine inject 30 units at bedtime scheduled for administration at 8:00pm. -Insulin glargine was documented as refused on 05/08/23, 05/13/23, 05/15/23, 05/16/23, 05/17/23, 05/18/23, 05/22/23, and 05/28/23. -Resident #5's FSBS ranged from 79 to 543 in May 2023. Interview with Resident #5 on 06/01/23 at 2:00pm revealed: -If her FSBS was too high or too low she made a decision herself whether she wanted to take insulin or not. -If she thought her FSBS was too low she would refuse insulin. -Sometimes when her FSBS was high she refused insulin because sometimes her FSBS would drop too low too fast if she took insulin. -Her FSBS was only high "once in a blue moon".	D 273		

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Interview with a medication aide (MA) on 06/01/23 at 11:18am revealed:
-Sometimes Resident #5 refused insulin.
-She documented on the eMAR when Resident #5 refused insulin.
-She had never reported to Resident #5's primary care provider (PCP) that the resident refused insulin.

Interview with a second MA on 06/01/23 at 3:59pm revealed:
-Resident #5 would usually not take insulin.
-She had not notified Resident #5's PCP that the resident refused insulin.
-She had made the former Resident Care Coordinator (RCC) and the Administrator aware that Resident #5 refused insulin.
-She used to notify the RCC or the Administrator every time Resident #5 refused insulin but the resident started refusing insulin so much that she only notified them sometimes now.

Interview with the Administrator on 06/01/23 at 2:36pm revealed:
-She knew Resident #5 refused insulin.
-She was not sure if Resident #5's PCP had been notified about the resident refusing insulin.
-She could not find any documentation in Resident #5's record that her PCP had been made aware that the resident was refusing insulin.

Telephone interview with a medical assistant at Resident #5's PCP's office on 06/01/23 at 2:22pm revealed:
-Resident #5 was last seen by the PCP in March 2023.
-She or the PCP's nurse did not see any documentation in Resident #5's chart that the PCP had been made aware that the resident had

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refused insulin.

Telephone interview with the facility's primary care provider (PCP) on 06/01/23 at 4:32pm revealed:
-She expected the facility to notify the PCP every time a resident refused medication.
-She used to receive notifications from the facility that certain residents were refusing medications, but she had not received any lately.
-It was important for the facility to let resident's PCPs know that a resident was refusing insulin because it could cause the resident to have high FSBSs which could cause long-term damage to the resident's kidneys and eyes.
-If the PCP was not aware that the resident was refusing insulin the PCP might increase the resident's insulin dosage to help with the higher FSBS which could overtreat the resident's FSBSs and cause hypoglycemia or to become ill.
-If she were notified that a resident was refusing insulin, she would speak to the resident to see why they were refusing insulin and see if she could place the resident on an oral diabetes medication instead.
-She would also evaluate the resident's FSBSs and see if she could switch the resident to a weekly insulin injection instead in conjunction with an oral diabetes medication.

Attempted telephone interview with Resident #5's PCP on 06/01/23 at 2:22pm was unsuccessful.

3. Review of Resident #13's current FL-2 dated 09/12/22 revealed:
-Diagnoses included cerebral palsy, mood disorder, intellectual disabilities, gait instability, and hypothyroidism.
-He was non-verbal.

Review of Resident #13's physician progress

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notes dated 02/14/23 revealed an order for Xanax 0.25mg, 1 tablet two times a day. (Xanax, also known as Alprazolam, is a medication used to treat anxiety and panic disorders).

Review of Resident #13's April 2023 electronic administration medication (eMAR) revealed:
-There was an entry for Xanax 0.25mg, 1 tablet twice a day at 8:00am and 8:00pm.
-There was documentation that Xanax 0.25mg, 1 tablet was not administered on 04/10/23 at 8:00am, 04/11/23 at 8:00am and 8:00pm and 04/12/23 at 8:00am with the notation "on hold."
-There was no documentation Xanax 0.25mg, 1 tablet was administered on 04/16/23 at 8:00pm (Blank).
-Resident #13 missed 5 doses of his scheduled Xanax during a 4-day period.

Review of Resident #13's May 2023 eMAR revealed:
-There was an entry for Xanax 0.25mg, 1 tablet twice a day at 8:00am and 8:00pm.
-There was documentation that Xanax 0.25mg, 1 tablet was not administered on 05/13/23 through 05/15/23 at 8:00am and 8:00pm and 05/16/23 at 8:00am with the notation "on hold."
-Resident #13 missed 7 doses of his scheduled Xanax during a 4-day period.

Telephone interview with a pharmacist at Resident #13's private pharmacy on 06/02/23 at 11:42am revealed:
-Resident #13 started using this pharmacy on 05/15/23.
-The resident's Xanax 0.25mg was dispensed for 60 tablets (30-day supply) on 05/15/23 and sent to the facility on 05/16/23.

Attempted telephone interview with Resident

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 11 #13's previous pharmacy on 06/01/23 at 11:50am was unsuccessful. Observation of Resident #13's medications on hand on 05/31/23 at 3:00pm revealed 30 tablets were in the bubble card with a dispense date of 05/15/23 and an expiration date of 05/20/24. Interview with Resident #13's family member on 06/01/23 at 2:10pm revealed; -She was not aware of any issues with the resident's medications. -She was aware there was a change in his private pharmacy due to the "abrupt" closing of the previous private pharmacy. Interview with the medication aide (MA) on 06/01/23 at 12:30pm revealed: -She did not administer Resident #13's Xanax on 05/15/23 and 05/16/23 at 8:00am because it was not available on the medication cart. -There was a change in pharmacy for Resident #13 that could be the reason the medication was not in the facility. -She notified the Administrator that Resident #13's Xanax was not available on the medication cart. -The notation "on hold" means the medication was not on the medication cart and waiting to be received from the pharmacy. -Resident #13 did not receive his Xanax for 3 or 4 days. Interview with a second MA on 06/01/23 at 4:30pm revealed: -She did not administer Resident #13's Xanax on 05/14/23 at 8:00pm because it was not available on the medication cart. -She notified the Administrator that Resident #13's Xanax was not available on the medication	D 273		

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cart.
-The notation "on hold" means the medication was not available on the medication cart but was on the way from the pharmacy.

Interview with the Administrator on 06/01/23 at 4:45pm revealed:
-Resident #13's private pharmacy closed abruptly in May 2023 and another private pharmacy was contracted by Resident #13's family.
-Because Xanax was a controlled medication, a "hard copy" prescription had to be signed and sent to the new pharmacy.
-She did not recall how long it took to receive the prescription but expected it to be filled as soon as possible.
-She was responsible for ensuring medications were in the facility.

Interview with the facility's contracted primary care provider (PCP) on 06/01/23 at 4:30pm revealed:
-She was not notified Resident #13 did not receive his Xanax as scheduled in April and May.
-She expected to be notified if Resident #13 was not receiving his Xanax as scheduled.
-Stopping Resident #13's Xanax abruptly could cause increased agitation, anxiety, heart palpitations and sweating.

Based on observations, record reviews, and interviews, it was determined Resident #13 was not interviewable.

4. Review of Resident #11's current FL-2 dated 02/23/23 revealed:
-Diagnoses included vascular dementia, insulin dependent diabetes mellitus (IDDM), hyperlipidemia, history of cerebral vascular accident (CVA), open angle glaucoma, recurrent

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falls, history of seizures, and history of breast cancer.
-She was intermittently disoriented.

a. Review of Resident #11's physician order dated 02/23/23 revealed there was an order to check finger stick blood sugars (FSBS) before each meal and contact the provider if the FSBS was less than 70 or greater than 250.

Review of a physician order dated 04/05/23 revealed there was a new order to check Resident #11's FSBS before each meal and contact the provider if the FSBS was less than 70 or greater than 400.

Review of Resident #11's March 2023 electronic administration record (eMAR) revealed:
-There was an entry to check FSBS three times a day before meals at 8:00am, 11:00am, and 4:00pm and call the provider for FSBS less than 70 or greater than 250.
-There was documentation the FSBS was greater than 250 at 8:00am from 03/09/23 through 03/11/23, 03/13/23 through 03/14/23, 03/18/23 and 03/20/23.
-There was documentation the FSBS was greater than 250 at 11:00am on 03/06/23, 03/08/23, 03/18/23, 03/20/23, 03/27/23, and 03/30/23.
-There was documentation FSBS was greater than 250 at 4:00pm on 03/04/23, 03/07/23 through 03/10/23, 03/14/23, 03/17/23, 03/19/23 through 03/22/23, and 03/24/23 through 03/27/23.
-There were 27 times in March that Resident #11's FSBS was greater than 250.

Review of Resident #11's April 2023 eMAR revealed:
-There was an entry to check FSBS three times a

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day before meals at 8:00am, 11:00am, and 4:00pm and call provider if FSBS was less than 70 or greater than 250.
-There was an entry that the ordered parameter for FSBS was discontinued dated 04/05/23.
-There was an entry to check FSBS three times a day before meals at 7:00am, 11:00am and 4:00pm and call provider if FSBS was less than 70 or greater than 400
-There was documentation that the FSBS was 309 at 4:00pm on 04/03/23.
-There was documentation that the FSBS was 373 at 8:00am on 04/04/23.
-There was documentation that the FSBS was 259 at 11:00am on 04/04/23.
-There was documentation that the FSBS was 577 at 4:00pm on 04/14/23.
-There was documentation that the FSBS was 421 at 7:00am on 04/15/23.
-There was documentation that the FSBS was 421 at 11:00am on 04/15/23.
-There was documentation that the FSBS was 538 at 11:00am on 04/22/23.
-Resident #11's FSBS were out of range 7 times in April 2023.

Review of Resident #11's May 2023 eMAR revealed:
-There was an entry to check FSBS three times a day before meals at 7:00am, 11:00am and 4:00pm and call provider if FSBS less than 70 or greater than 400.
-There was documentation that the FSBS was 425 at 4:00pm on 05/17/23.
-There was documentation that the FSBS was 406 at 4:00pm on 05/22/23.
-Resident #11 FSBS were out of range 2 times (greater than 400) in May 2023.

Review of Resident #11's record revealed there

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was no documentation that the provider was notified for BSs greater than 250 in March 2023 and BSs greater than 400 for April 2023 and May 2023 as ordered.

Interview with the Administrator on 06/01/23 at 4:45pm revealed:
-Resident #11 had her own private PCP.
-Documentation of PCP notification for Resident #11's FSBS parameters being out of range was requested by the surveyor.
-She did not know if Resident #11's FSBS being out of range or not receiving her insulin was reported to her private PCP.
-When there were parameters out of range for a resident, if the facility's contracted PCP was the resident's provider, the facility notified the PCP via the telemetric system .
-If the resident had a private PCP, the provider would be notified via a telephone call or fax and documented in the progress notes.

-Interview with the facility's contracted primary care provider (PCP) on 06/01/23 at 5:50pm revealed:
-It was important to notify a PCP of FSBSs outside of parameters so the PCP would be able to treat the resident accordingly.
-If a resident's FSBS was too low the PCP should be contacted so they could instruct facility staff on how to treat the low FSBS and to monitor to make sure the FSBS responded to the treatment.
-If a resident's FSBS was too high a PCP should be contacted so they could instruct facility staff on how to treat the high FSBS.
-Depending on how high the FSBS was, the treatment might be to wait and recheck the FSBS again or treatment might involve administering a short-acting insulin to the resident to bring the FSBS down.

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D 273	Continued From page 16 Attempted telephone interview with Resident #11's PCP on 06/01/23 at 11:00am was unsuccessful. b. Review of a physician order dated 02/23/23 revealed there was an order to check Resident #11's blood pressure (BP) daily and contact the private (PCP) if less than 90/60 or greater than 150/90. Review of Resident #11's March 2023 eMAR revealed: -There was an entry to check blood pressure daily and call provider if less than 90/60 or greater than 150/90. -There was documentation that Resident #11's BP was 168/92 on 03/17/23. -There was no documentation the PCP was contacted. -There was documentation that Resident #11's BP was 162/94 on 03/31/23. -There was no documentation the PCP was contacted. Review of Resident #11's April 2023 eMAR revealed: -There was an entry to check blood pressure daily and call provider if less than 90/60 or greater than 150/90. -There was documentation that Resident #11's BP was 178/99 on 04/18/23. -There was no documentation the PCP was contacted. -There was documentation that Resident #11's BP was 161/94 on 04/27/23. -There was no documentation the PCP was contacted. -There was documentation that Resident #11's BP was 162/93 on 04/29/23.	D 273		

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D 273	Continued From page 17 -There was no documentation the PCP was contacted. Review of Resident #11's May 2023 eMAR revealed: -There was an entry to check blood pressure daily and call provider if less than 90/60 or greater than 150/90. -There was documentation that Resident #11's BP was 181/89 on 05/02/23. -There was no documentation the PCP was contacted. -There was documentation that Resident #11's BP was 178/93 on 05/03/23. -There was no documentation the PCP was contacted. -There was documentation that Resident #11's BP was 189/96 on 05/22/23. -There was no documentation the PCP was contacted. -There was documentation that Resident #11's BP was 159/95 on 05/24/23. -There was no documentation the PCP was contacted. Review of the 2023 American Heart Association Guidelines revealed: -Blood pressure consisted of two numbers such as 120/80. -The top number was the pressure as your heart beats and pushes blood through the blood vessels, called "systolic" pressure. -The bottom number was the pressure when the vessels relax between heart beats and was called " diastolic" pressure. -Normal BP was 120/80, high BP (hypertensive stage 1) was the systolic value of 130-139 or the diastolic value of 80/89, high BP (hypertensive stage 2) was the systolic value of 140 or higher or the diastolic value of 90 or higher, hypertensive	D 273		

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crisis was when the systolic value was greater than 180 and/ or the diastolic value was greater than 120 (call MD immediately).
-The threats of high BP was a stoke, vision loss (blindness), heart failure or heart attack.

Review of Resident #11's record revealed there was no documentation that the provider was notified for BPs greater than 150/90 for March 2023, April 2023, and May 2023 as ordered.

Interview with the Administrator on 06/01/23 at 4:45pm revealed:
-She did not know if Resident #11's BP parameters being out of range was reported to her private PCP.
-When there were parameters out of range for a resident, if the facility's contracted PCP was the resident's provider, the facility notified the PCP via the telemetric system .
-If the resident had a private PCP, the provider would be notified via a telephone call or fax and documented in the progress notes.
-Resident #11 had her own private PCP.
-Documentation of PCP notification for Resident #11's BP parameters being out of range was requested by the surveyor.

Interview with the facility's primary care provider (PCP) on 06/01/23 at 5:50pm revealed:
-It was important to be notified of a BP out of range so a PCP could notice trends with a resident's BP so they could adjust medications if needed.
-If the facility contacted her regarding elevated BPs she would have the facility recheck the BP later to make sure the BP was still not elevated.

Based on observations, record reviews, and interviews, it was determined Resident #11 was

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D 273	Continued From page 19 not interviewable. Attempted telephone interview with Resident #11's PCP on 06/01/23 at 11:00am was unsuccessful. _____ The facility failed to ensure follow-up to meet the acute health care needs of 4 of 5 sampled residents. The facility failed to inform the primary care provider (PCP) that a resident (#2) had a toxic level of medication in her blood for which she needed monitoring and for failing to notify the PCP that a resident (#5) refused 152 doses of short-acting insulin and refused 11 doses of long-acting insulin which could cause the resident to have high fingerstick blood sugars (FSBS) which could cause long-term damage to the residents kidneys and eyes. The facility also failed to notify the PCP that a resident (#13) was out of a medication used to treat anxiety which could have caused withdrawal symptoms such as agitation, anxiety, and heart palpitations and failed to notify the PCP of a resident's (#11) elevated FSBSs which could cause long-term damage to the kidneys and eyes and high blood pressures which could lead to stoke, vision loss, heart failure, or heart attack. These failures were detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131 D-34 on 02/22/23. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 16, 2023.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care	D 276		

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10A NCAC 13F .0902 Health Care
(c) The facility shall assure documentation of the following in the resident's record:
(3) written procedures, treatments or orders from a physician or other licensed health professional; and
(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure physician's orders were implemented for 8 of 8 residents (#5,#6,#7,#8,#9, #10, #11 and #12) who were ordered finger stick blood glucose monitoring.

The findings are:

1. Review of Resident #5's current FL-2 dated 02/13/23 revealed
-Diagnoses included insulin dependent type 2 diabetes.
-There was an order to check fingerstick blood sugar (FSBS) 3 times a day.

Review of Resident #5's May 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for check FSBS 3 times a day scheduled at 8:00am, 12:00pm, and 4:00pm.
-FSBS was documented as refused at 8:00am and 12:00pm on 05/14/23.
-FSBS was documented as 391 at 4:00pm on 05/14/23.

Interview with Resident #5 on 05/31/23 at 8:50am revealed:
-She was on a couple of different insulins for her diabetes.

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D 276	Continued From page 21 -She received FSBS checks 4 times a day. -The facility sometimes ran out of blood glucose strips. -There were 2 times a couple of weeks ago that her FSBS was not checked because the facility was out of blood glucose strips. Refer to interview with a medication aide (MA) on 06/01/23 at 10:30am. Refer to second interview with a MA on 06/01/23 at 3:45pm. Refer to third interview with a MA on 06/01/23 at 4:50pm. Refer to interview with the Administrator on 06/01/23 at 2:47pm. Refer to second interview with the Administrator on 06/01/23 at 3:00pm. Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 06/01/23 at 11:42am. Refer to telephone interview with the facility's contracted primary care provider (PCP) on 06/01/23 at 4:32pm. 2. Review of Resident #11's current FL-2 dated 02/23/23 revealed: -Diagnoses included vascular dementia, insulin dependent diabetes mellitus (IDDM), hyperlipidemia, history of cerebral vascular accident (CVA), open angle glaucoma, recurrent falls, history of seizures, and history of breast cancer. -She was intermittently disoriented.	D 276		

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D 276	Continued From page 22 Review of Resident #11's physician order dated 02/23/23 revealed there was a order to check finger stick blood sugar (FSBS) three times a day before meals. Review of Resident #11's March 2023 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS three times a day before meals at 8:00am, 11:00am and 4:00pm -There was no documentation that FSBS was done on 03/09/23 at 11:00am due to on hold, 03/12/23 at 7:00am and 11:00am due to refused, 05/13/23 at 11:00am no reason documented, 03/15/23 at 4:00pm due to internet down, 03/16/23 at 4:00pm due to refused, 03/18/23 at 4:00pm due to refused, 03/23/23 at 8:00am due to refused and 03/30/23 at 4:00pm due to resident unavailable. Review of Resident #11's April 2023 eMAR revealed: -There was an entry to check FSBS three times a day before meals at 7:00am, 11:00am and 4:00pm. -There was no documentation that FSBS was done on 04/12/23 at 4:00pm due to refused, and 04/13/23 at 7:00am and 11:00am due to refused. Review of Resident #11's May 2023 eMAR revealed: -There was an entry to check FSBS three times a day before meals. -There was no documentation that FSBS was done on 05/04/23 at 4:00pm due to refused, 05/14/23 at 7:00am and 11:00am due to refused, 05/15/23 at 4:00pm due to refused, and 05/17/23 at 4:00pm due to on hold.	D 276		

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D 276	Continued From page 23 Refer to interview with a medication aide (MA) on 06/01/23 at 10:30am. Refer to second interview with a MA on 06/01/23 at 3:45pm. Refer to third interview with a MA on 06/01/23 at 4:50pm. Refer to interview with the Administrator on 06/01/23 at 2:47pm. Refer to second interview with the Administrator on 06/01/23 at 3:00pm. Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 06/01/23 at 11:42am. Refer to telephone interview with the facility's contracted primary care provider (PCP) on 06/01/23 at 4:32pm. 3. Review of Resident #9's current FL-2 dated 09/14/22 revealed: -Diagnoses included Type II diabetes and lack of coordination. -She was ambulatory and intermittently disoriented. Review of Resident #9's physician's order dated 11/04/22 revealed an order for finger stick blood sugar (FSBS) twice daily. Review of Resident #9's physician's order dated 05/11/23 revealed an order for FSBS to be obtained three times a day before meals at 7:00am, 11:30am and 4:30pm. Review of Resident #9's electronic medication	D 276		

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administration record (eMAR) for May 2023 revealed:
-There was an entry for FSBS to be obtained twice daily from 05/01/23 to 05/10/23.
-There was documentation FSBS checks were obtained twice daily from 05/01/23 to 05/10/23 at 8:00am and 8:00pm.
-There was an entry for FSBS to be obtained three times daily beginning 05/11/23.
-There was documentation FSBS checks were not obtained at 7:45am 05/14/23 with an exception note stating the testing strips were unavailable.

Interview with Resident #9's primary care provider (PCP) on 06/01/23 at 4:30pm revealed it was important Resident #9's blood sugar was monitored because her blood sugar levels frequently ran high and her kidneys were compromised due to diabetes.

Refer to interview with a medication aide (MA) on 06/01/23 at 10:30am.

Refer to second interview with a MA on 06/01/23 at 3:45pm.

Refer to third interview with a MA on 06/01/23 at 4:50pm.

Refer to interview with the Administrator on 06/01/23 at 2:47pm.

Refer to second interview with the Administrator on 06/01/23 at 3:00pm.

Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 06/01/23 at 11:42am.

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D 276	Continued From page 25 Refer to telephone interview with the facility's contracted primary care provider (PCP) on 06/01/23 at 4:32pm. 4. Review of Resident #6's current FL-2 dated 08/10/22 revealed diagnoses included Type II diabetes. Review of Resident #6's physician's order dated 10/20/22 revealed an order for finger stick blood sugar (FSBS) checks three times a day. Review of Resident #6's electronic medication administration record (eMAR) for May 2023 revealed: -There was an entry for FSBS to be obtained three times a day. -There was documentation a FSBS was not obtained at 11:30am on 05/14/23 with an exception note stating monitor strips were unavailable. Refer to interview with a medication aide (MA) on 06/01/23 at 10:30am. Refer to second interview with a MA on 06/01/23 at 3:45pm. Refer to third interview with a MA on 06/01/23 at 4:50pm. Refer to interview with the Administrator on 06/01/23 at 2:47pm. Refer to second interview with the Administrator on 06/01/23 at 3:00pm. Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 06/01/23 at 11:42am.	D 276		

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D 276	Continued From page 26 Refer to telephone interview with the facility's contracted primary care provider (PCP) on 06/01/23 at 4:32pm. 5. Review of Resident #7's current FL-2 dated 01/04/23 revealed: -Diagnoses included acquired absence of his left leg below the knee, generalized muscle weakness and abnormal posture. -He was semi-ambulatory. -There was no documentation for orientation. Review of Resident #7's physician's progress note dated 03/09/23 revealed a diagnosis of Type II diabetes with circulatory complications. Review of Resident #7's physician's order dated 01/29/23 revealed an order for finger stick blood sugar (FSBS) checks three times a day before meals and once before bed for a total of four times daily. Review of Resident #7's electronic medication administration record (eMAR) for May 2023 revealed: -There was an entry for FSBS to be obtained 4 times daily. -There was documentation Resident #9's FSBS was not obtained on 05/13/23 at 8:00pm with an exception note stating "unable to get blood check". -There was documentation Resident #9's FSBS was not obtained on 05/14/23 at 8:00am with an exception note stating testing strips were unavailable. Refer to interview with a medication aide (MA) on 06/01/23 at 10:30am.	D 276		

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Refer to second interview with a MA on 06/01/23 at 3:45pm.

Refer to third interview with a MA on 06/01/23 at 4:50pm.

Refer to interview with the Administrator on 06/01/23 at 2:47pm.

Refer to second interview with the Administrator on 06/01/23 at 3:00pm.

Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 06/01/23 at 11:42am.

Refer to telephone interview with the facility's contracted primary care provider (PCP) on 06/01/23 at 4:32pm.

6. Review of Resident #8's current FL2 dated 11/23/22 revealed:
-Diagnosis included hypertension, paroxysmal atrial fibrillation, diabetes, congenital stenosis of aortic, hypothyroidism and chronic kidney value disease.
-There was an order to check blood sugar, but it was not noted how often.

Review of Resident #8's Licensed Health Professional Support (LHPS) dated 12/28/22 revealed:
-Collection and testing of fingerstick blood samples.
-Medication administration through injection.

Review of Resident #8's May 2023 electronic medication administration record (eMAR) revealed:
-There was an entry to check finger sticks blood

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sugar (FSBS) two times a day before meals at 8:00am and 8:00pm.
-There was no documentation that a FSBS was completed on 05/13/23 at 8:00pm due to blood glucose stripes not being available.
-There was no documentation that FSBS was completed on 05/14/23 at 8:00am due to Resident #8 refusal.

Based on observations, record reviews, and interviews, it was determined that Resident #8 was not interviewable.

Refer to interview with a medication aide (MA) on 06/01/23 at 10:30am.

Refer to second interview with a MA on 06/01/23 at 3:45pm.

Refer to third interview with a MA on 06/01/23 at 4:50pm.

Refer to interview with the Administrator on 06/01/23 at 2:47pm.

Refer to second interview with the Administrator on 06/01/23 at 3:00pm.

Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 06/01/23 at 11:42am.

Refer to telephone interview with the facility's contracted primary care provider (PCP) on 06/01/23 at 4:32pm.

7. Review of Resident #10's current FL-2 dated 05/04/23 revealed diagnoses included diabetes.

Review of Resident #10's physician order sheet

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dated 05/01/23 revealed there was an order for fingerstick blood sugars (FSBS) 3 times a day.

Review of Resident #10's May 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for check FSBS 3 times daily scheduled at 7:00am, 11:00am, and 4:00pm.
-FSBS was documented as refused at 7:00am and 11:00am on 05/14/23.

Refer to interview with a medication aide (MA) on 06/01/23 at 10:30am.

Refer to second interview with a MA on 06/01/23 at 3:45pm.

Refer to third interview with a MA on 06/01/23 at 4:50pm.

Refer to interview with the Administrator on 06/01/23 at 2:47pm.

Refer to second interview with the Administrator on 06/01/23 at 3:00pm.

Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 06/01/23 at 11:42am.

Refer to telephone interview with the facility's contracted primary care provider (PCP) on 06/01/23 at 4:32pm.

8. Review of Resident #12's current FL-2 dated 11/09/22 revealed diagnoses included coronary artery disease, accelerated hypertension, congestive heart failure, ischemic dilated cardiomyopathy, hypertension, and acute respiratory distress.

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D 276	Continued From page 30 Review of a physician order dated 04/17/23 revealed there was an order to check finger stick blood sugar (FSBS) before breakfast and bedtime. Review of Resident #12's May 2023 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS twice a day before breakfast at 6:30am and at bedtime at 8:00pm. -There was no documentation that FSBS was obtained on 05/14/23 at 6:30am with the notation refused. Refer to interview with a medication aide (MA) on 06/01/23 at 10:30am. Refer to second interview with a MA on 06/01/23 at 3:45pm. Refer to third interview with a MA on 06/01/23 at 4:50pm. Refer to interview with the Administrator on 06/01/23 at 2:47pm. Refer to second interview with the Administrator on 06/01/23 at 3:00pm. Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 06/01/23 at 11:42am. Refer to telephone interview with the facility's contracted primary care provider (PCP) on 06/01/23 at 4:32pm. _____ Interview with a medication aide (MA) on	D 276		

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D 276	Continued From page 31 06/01/23 at 10:30am revealed: -Sometimes the facility ran short on having blood glucose test strips for testing FSBS. -Finger stick blood sugars could not be done without the blood glucose test strips. -Insulin could not be administered without knowing the FSBS value if the resident was on a sliding scale. -She would notify the Administrator when blood glucose test strips were running low or were out. -She did not know the process for ordering supplies for the facility. Interview with a second MA on 06/01/23 at 3:45pm. revealed: -Sometimes the facility ran out of blood glucose test strips for testing FSBS. -She would notify the Administrator when blood glucose test strips were needed. Interview with a third medication aide (MA) on 06/01/23 at 4:50pm revealed: -The former Resident Care Coordinator (RCC) was responsible for and used to ensure supplies, including blood sugar test strips, were available for use. -The Administrator had taken on the roll of RCC and was now responsible for ensuring the supplies were available. -She informed the Administrator that test strips were needed on 05/12/23. -There were no test strips available for FSBS testing from the afternoon of 05/13/23 until evening shift on 05/14/23. Interview with the Administrator on 06/01/23 at 2:47pm revealed: -She was notified by a MA at 3:48pm on 05/13/23 that the facility was running low on blood glucose strips.	D 276		

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D 276	Continued From page 32 -The facility had an overstock supply of blood glucose strips. -The MA told her that she had pulled the last bottle of blood glucose strips from the overstock supply on 05/12/23. -Once she was notified by the MA that the facility was running low on blood glucose strips she contacted a local pharmacy and ordered blood glucose strips for the facility. -She text a MA at the facility at 6:00am on 05/14/23 and made her aware the blood glucose strips were ready to be picked up from the local pharmacy and that someone needed to go retrieve them. -She assumed someone went to pick up the blood glucose strips at that time. -She did not know that no one had picked up the blood glucose strips until around 3:00pm on 05/14/23 when another MA notified her that there were no blood glucose strips in the facility. -She told the MA that the blood glucose strips were at a local pharmacy and someone needed to go retrieve them. Second interview with the Administrator on 06/01/23 at 3:00pm revealed: -The former RCC was responsible for ensuring supplies were available but she took over the RCC role in April 2023. -There was no process in place for monitoring the use or supply of blood sugar test strips. -She relied on the MAs to tell her when the test strips were needed. Interview with a pharmacist at the facility's contracted pharmacy on 06/01/23 at 11:42am revealed the facility did not receive blood glucose strips from the pharmacy but used another supplier to provide them with blood glucose strips.	D 276		

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D 276	Continued From page 33 Telephone interview with the facility's contracted primary care provider (PCP) on 06/01/23 at 4:32pm revealed: -She did not know that the facility had run out of glucose strips in May 2023. -It was important that residents received FSBS checks as ordered especially if they were taking insulin or an oral diabetes agent. -If a resident was on sliding scale insulin it was important for them to have their FSBS checked as ordered so the right amount of insulin could be administered. -Not administering sliding scale insulin to a resident because the facility was unable to check a FSBS could lead to the resident having a high FSBS.	D 276		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments 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 Based on observations, record reviews and interviews the facility failed to administer medications as ordered for 8 of 12 sampled residents (#2, #3, #5, #7, #8, #9, #11, #13) including errors with a seizure medication (#2), an	D 358		

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antibiotic and a medication used to treat urinary frequency (#3), insulin (#5, #11), a medication used to treat anxiety (#13, #8), a pain medication and a sleep medication (#7), and a cream used to treat fungal infections (#9).

The findings are:

1. Review of Resident #2's current FL-2 dated 05/15/22 revealed:
-Diagnoses included hypertension, metabolic encephalopathy (chemical imbalance in the blood that affects the brain), acute kidney failure, and major depressive disorder.
-Resident #2 was semi-ambulatory.
-There was an order for Tegretol 200mg take 2 tablets 3 times a day (According to manufacturer's instructions Tegretol is used to treat certain types of seizures and certain types of nerve pain. Periodic laboratory (lab) testing should be done to monitor for drug toxicity. Symptoms of Tegretol toxicity include irregular breathing pattern, increased heart rate, impairment of consciousness, drowsiness, dizziness, nausea, vomiting, and convulsions).

Review of Resident #2's event summary list revealed:
-An accident/incident (A/I) report was completed on 03/09/23 stating a "medical event" occurred at 11:15pm on 03/09/23.
-There was no indication what the medical event was.

Review of Resident #2's progress notes revealed there was no entry on 03/09/23.

Review of Resident #2's emergency department (ED) note dated 03/09/23 revealed:
-Resident #2 was brought into the ED by

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Emergency Management Services (EMS) due to vomiting.
-Resident #2 was able to communicate but was lethargic.
-A Tegretol level was performed on Resident #2 with a value of 20.0 ug/mL (A therapeutic Tegretol value is 4.0 to 10.0 ug/mL).
-Resident #2 was diagnosed with nausea and vomiting and a right renal mass.
-Resident #2 was discharged on 03/10/23 with instructions to stop Tegretol for 3 days and then resume and recheck a Tegretol level in 1 week.

Review of Resident #2's record revealed:
-There was a hospital after visit summary dated 03/10/23 stating Resident #2's Tegretol level was high.
-There was an order to stop Tegretol for 3 days, then resume; recheck Tegretol level in 1 week.

Review of Resident #2's progress note dated 03/14/23 revealed the resident was sent to the ED because she had a seizure.

Review of Resident #2's ED note dated 03/14/23 revealed:
-Resident #2 was brought in by EMS due to having a seizure.
-A Tegretol level was performed on Resident #2 with a value of 16.1 ug/mL.
-A report was called to staff at the facility.
-It was confirmed with facility staff that Resident #2 had "continued to receive Tegretol after being seen on the 9th with a critical level of 20 and instructed to hold Tegretol for 3 days then resume with new blood work".
-The facility staff was educated on Tegretol toxicity levels and toxicity outcomes.
-New Tegretol levels remained "critical at 16" and the ED provider ordered to hold Tegretol for 2

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D 358	Continued From page 36 days. -When speaking to facility staff the ED nurse "stressed that these instructions must be followed, otherwise the patient could end up severely harmed or it could result in her death". -Resident #2 was discharged to the facility on 03/14/23 at 11:01pm. Review of Resident #2's March 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Tegretol 200mg take 2 tablets 3 times a day scheduled for administration at 9:00am, 3:00pm, and 9:00pm. -Tegretol 200mg 2 tablets was documented as administered at 9:00am and 3:00pm on 03/01/23 to 03/14/23. -Tegretol 200mg 2 tablets was documented as administered at 9:00pm on 03/01/23 to 03/13/23 except on 03/14/23 where it was documented "resident unavailable". -Tegretol 200mg 2 tablets was not held for 3 days as ordered on 03/10/23, 03/11/23, and 03/12/23. -Tegretol 200mg 2 tablets was documented as "on hold" at 9:00am, 3:00pm, and 9:00pm on 03/15/23 to 03/17/23. -Tegretol 200mg 2 tablets was documented as administered at 9:00am on 03/18/23. -Tegretol 200mg 2 tablets was documented as refused at 3:00pm, and 9:00pm on 03/18/23. -Tegretol 200mg 2 tablets was documented as refused at 9:00am, 3:00pm, and 9:00pm on 03/19/23 and at 9:00am on 03/20/23. -Tegretol 200mg was documented as discontinued at 3:00pm and 9:00pm on 03/20/23. Review of Resident #2's progress notes revealed the primary care provider (PCP) was notified of a change in condition on 03/19/23.	D 358		

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D 358	Continued From page 37 Review of Resident #2's record revealed she was placed on hospice on 03/20/23 and all scheduled medications were discontinued. Interview with Resident #2's family member on 05/31/23 at 2:45pm revealed: -Resident #2 was sent to the hospital for nausea and vomiting sometime in March 2023 but she could not remember the exact date. -When she arrived at the hospital to see Resident #2, she was told that her seizure medication was elevated and that she had a mass in her head and stomach. -On Resident #2's discharge paperwork it stated to take Resident #2 off her seizure medication so her level could return to normal. -The discharge paperwork was sent to the facility with Resident #2. -She spoke to the former Resident Care Coordinator (RCC) a few days later and asked if Resident #2's seizure medication had been stopped but never received a reply from the RCC. -The same day that she spoke with the RCC about the seizure medication Resident #2 went to the hospital again and her seizure medication level was lower than it was, but it was still too high. -Someone from the hospital spoke to someone at the facility and it was confirmed that Resident #2's seizure medication was never stopped by the facility. -A few days later Resident #2 was "out of it" and "delirious" so the family asked for medication to calm the resident. -The next day Resident #2 was placed on hospice, and she passed away a day later. Review of Resident #2's death certificate dated 03/21/23 revealed the cause of death was renal cancer.	D 358		

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D 358	Continued From page 38 Interview with a medication aide (MA) on 05/31/23 at 2:32pm revealed: -She remembered speaking with someone at the hospital about Resident #2 and they told her that the resident had discontinue orders for one of her medications the last time she was discharged from the hospital. -She verified with the person at the hospital that the medication was never stopped for Resident #2. -She did not remember the name of the medication or the purpose of the medication. -When Resident #2 came back from the hospital after that she was weak but was doing well for a few days. -When she came back to the facility after a couple of days off Resident #2 was no longer getting up out of bed. Interview with the Administrator on 05/31/23 at 2:02pm revealed: -When the facility received new orders for a resident the MA that received the orders processed the orders. -If the orders came from the resident's PCP they were faxed to the resident's pharmacy by the MA. -If new orders were received after a resident returned from the hospital the new orders were faxed to the resident's pharmacy as well as the resident's PCP. -MAs were expected to fax the orders to the pharmacy as soon as the order was received. -There was a "bucket system" in place to make sure orders were processed correctly. -When the orders were received, they were placed into a folder. -Once the orders were approved and the treatment was started the orders were placed into a different folder.	D 358		

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-The folders were checked daily by the former RCC.
-The RCC was no longer employed at the facility as of 04/18/23 and she had been taking over her duties until a new RCC was hired.
-The facility's contracted pharmacy profiled medications on the resident's eMAR.
-No one in the facility could make changes on the eMAR.
-The facility was unable to discontinue medications on the eMAR and that had to be done by the pharmacy.
-She thought someone in the facility could place medications on hold on the eMAR but she was not sure.
-She thought any changes that the pharmacy made on the eMAR had to be approved by someone at the facility, but she was not sure.
-She was not aware that Resident #2's Tegretol had not been held for 3 days as ordered.
-The order to hold Resident #2's Tegretol should have been faxed to the facility's contracted pharmacy as soon as it was received by the facility.

Second interview with the Administrator on 06/01/23 at 3:00pm revealed:
-Orders were usually sent to the pharmacy by the primary care provider.
-There were times the facility obtained orders and it would take the provider a few days to sign them so there would be a delay in the order being sent.
-New orders were entered onto the eMAR by the pharmacy.
-The former RCC was responsible for ensuring medications were entered as ordered by the provider and approving the order in the eMAR system so that the medication could be administered.
-The former RCC was responsible for ensuring

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D 358	Continued From page 40 orders were received by the pharmacy and the medications were administered as ordered. Interview with a pharmacist at the facility's contracted pharmacy on 06/01/23 at 2:12pm revealed: -The facility should fax any new orders to the pharmacy including those received from a hospital visit. -The facility's contracted pharmacy did not receive any orders from the facility on 03/10/23 to hold Resident #2's Tegretol for 3 days. -The facility could not discontinue a medication on the eMAR but they could place a medication on hold if it was ordered to be on hold. -The facility was expected to place a medication on hold on the eMAR if the medication was stopped for less than 10 days. -If a medication was stopped for more than 10 days the pharmacy would request a discontinue order and a restart date and place those on the eMAR. -The facility's contracted pharmacy received an order from the facility on 03/14/23 to hold Resident #2's Tegretol for 2 days. Interview with Resident #2's primary care provider (PCP) on 06/01/23 at 4:32pm revealed: -She expected any new orders for residents to be implemented by the facility within 24 hours of receiving the orders. -She thought Resident #2 was receiving Tegretol for a seizure disorder, but she was not sure because she did not have the resident's records with her. -She was not aware that Resident #2 had an elevated Tegretol level when she went to the hospital on 03/09/23. -She was not aware that the facility was to hold Resident #2's Tegretol for 3 days.	D 358		

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-She was not aware that the facility did not hold Resident #2's Tegretol as ordered, and that the resident returned to the ED with an elevated Tegretol level a few days later.
-A Tegretol level of 20.0 ug/mL was considered toxic.
-It was important that Resident #2's Tegretol be held as ordered since her level was toxic and if she continued to receive the medication her level would remain toxic.
-A Tegretol level of 16.1 ug/mL was considered toxic.
-She was unsure of what side effects a toxic Tegretol level could cause.

2. Review of Resident #3's current FL-2 dated 02/14/23 revealed diagnoses included congestive heart failure, coronary artery disease, essential hypertension, atrial fibrillation, diabetes mellitus, stage 3 chronic kidney disease, overactive bladder, and chronic pain syndrome.

a. Review of Resident #3's urology after visit summary dated 04/27/23 revealed an order for Bactrim double strength (DS) 1 tablet twice daily for 7 days (Bactrim is an antibiotic used to treat bacterial infections).

Review of Resident #3's April 2023 electronic medication administration record (eMAR) revealed:
-There was no entry for Bactrim DS 1 tablet twice daily for 7 days.
-There was no documentation that Bactrim DS 1 tablet twice daily for 7
days was administered from 04/27/23 to 04/30/23.

Review of Resident #3's May 2023 eMAR revealed:

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-There was an entry for Bactrim 800-160mg every 12 hours for 7 days scheduled for administration at 8:00am and 8:00pm.
-Bactrim 800-160mg was not documented as administered at 8:00am and 8:00pm on 05/01/23.
-Bactrim 800-160mg was not documented as administered at 8:00am on 05/02/23.
-Bactrim 800-160mg was documented as administered at 8:00pm on 05/02/23 and at 8:00am and 8:00pm on 05/03/23 to 05/09/23.

Interview with a resident representative on 05/19/23 at 4:12pm revealed:
-She met with Resident #3 at the facility on 05/02/23.
-Resident #3 stated she was supposed to be taking an antibiotic, but 5 days had passed and she had not received it.
-She spoke with the former Resident Care Coordinator (RCC) and a medication aide (MA) about Resident #3's medication on 05/02/23.
-She was told by the RCC and the MA that the facility had not received Resident #3's medication due to a pharmacy issue.
-Resident #3 eventually received her antibiotic after the complainant brought it to the Administrator's attention.

Interview with Resident #3 on 05/23/23 at 2:49pm revealed the urologist prescribed her an antibiotic and it took her 5 days to receive the medication.

b. Review of Resident #3's urology after visit summary dated 04/27/23 revealed an order for Ditropan 5 mg daily (Ditropan is used to treat frequent or urgent urination).

Review of Resident #3's April 2023 electronic administration record (eMAR) revealed:
-Three was no entry for Ditropan 5mg daily.

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D 358	Continued From page 43 -There was no documentation that Ditropan 5mg was administered from 04/27/23 to 04/30/23. Review of Resident #3's May 2023 eMAR revealed: -There was an entry for Ditropan 5mg once daily scheduled for administration at 8:00am. -Ditropan 5mg was not documented as administered 05/01/23 to 05/03/23. -Ditropan 5mg was documented as administered 05/04/23 to 05/31/23 except on 05/13/23 where it was documented as on hold. Interview with Resident #3 on 05/23/23 at 2:49pm revealed: -About 2 weeks ago she went to a bladder doctor because she had a bad urinary tract infection (UTI). -The prescribed medications were on the medication cart because her private pharmacy delivered it the same day that she went to her urology appointment. -Resident #3 asked the 1st shift MA about the medications and the MA told her the medications were in the building, but she did not have an order to administer the medications. -She asked the 2nd shift MA about the medications, and she told her she did not have an order to administer the medications. -She told the Administrator she needed to talk with her, but the Administrator never got back with her until the a resident representative came to visit with her. -She was told by the former Resident Care Coordinator (RCC) the facility had to get approval from their contracted pharmacy before they could use her private pharmacy. Second interview with Resident #3 on 06/01/23 at 9:30am revealed:	D 358		

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D 358	Continued From page 44 -She went to her urology appointment to have a procedure but could not have it done until the UTI was cleared. -Her urine was cloudy, she was having spasms of her bladder, and she was urinating every hour. -She told a MA that her urologist ordered her medications to treat her UTI and bladder spasms. -The MA told Resident #3 the medication was on the medication cart, but she could not give it to her because she did not have an order for it. -She went to the same MA the next day and the MA told her she still could not give her the medication. -She felt bad and was itching and urinating every hour. -About 4 days later, her urologist called asking her if the medications were working. -She told the urologist she did not have the medications and he told Resident #3 he was going to call the facility. -She started receiving the medications the next day. Interview with a MA on 05/23/23 at 3:48pm revealed: -Resident #3 told her she was supposed to be receiving new medications. -She told Resident #3 the medications were not in the computer so she could not administer it to her. -She did not recall if the medications were on the medication cart. Interview with a second MA on 06/01/23 at 8:15am revealed: -Resident #3 told her about the medications when she returned from her doctor's appointment. -Resident #3's urologist sent an order for the medications to the resident's private pharmacy but did not send the order to the facility.	D 358		

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D 358	Continued From page 45 -She and another MA contacted Resident #3's urologist to have the medication orders sent to the facility. -The facility's contracted pharmacy had to profile the medications on the MAR before staff could administer the medications since it was sent to Resident #3's private pharmacy. -She thought the medication orders were sent to the facility the day after Resident #3's urology appointment. Interview with the Administrator on 05/31/23 at 2:02pm revealed: -When the facility received new orders for a resident the MA that received the orders processed the orders. -If the orders came from the resident's primary care provider (PCP) they were faxed to the resident's pharmacy by the MA. -If new orders were received after a resident returned from the hospital the new orders were faxed to the resident's pharmacy as well as the resident's PCP. -MAs were expected to fax the orders to the pharmacy as soon as the order was received. -There was a "bucket system" in place to make sure orders were processed correctly. -When the orders were received, they were placed into a folder. -Once the orders were approved and the treatment was started the orders were placed into a different folder. -The folders were checked daily by the former RCC. -The RCC was no longer employed at the facility as of 04/18/23 and she had been taking over her duties until a new RCC was hired. Second interview with the Administrator on 06/01/23 at 9:23am revealed:	D 358		

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D 358	Continued From page 46 -When Resident #3's medication arrived at the facility from the resident's private pharmacy, the facility did not have an order for the medication. -A facility staff member called the resident's private pharmacy to have a copy of the medication order sent to the facility. -A MA went to Resident #3's room to get the after-visit summary from the resident. -The MA faxed the after-visit summary with the medication order on it to the facility's contracted pharmacy. -She was not sure if the medication order was sent to the facility the same day Resident #3 came back from her urology appointment. Interview with a nurse at Resident #3's urologist office on 06/01/23 at 12:15pm revealed: -Resident #3 was seen in the office on 04/27/23 for recurrent UTI and overactive bladder. -She was prescribed Bactrim for the UTI and Ditropan for overactive bladder. -He was not sure if the facility called the office to ask for an order for the medication. -He called Resident #3 on either 05/01/23 or 05/02/23 to ask how the medications were working. -Resident #3 informed him that she did not have the medications. -He informed the resident that he was going to contact the facility about her medications. -He called to inform the facility about resident #3 medications. -He spoke with a MA at the facility on 05/02/23 and gave a verbal order for the medications over the telephone. 3. Review of Resident #5's current FL-2 dated 02/13/23 revealed: -Diagnoses included insulin dependent type 2 diabetes.	D 358		

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D 358	Continued From page 47 -There was an order for lancets use to check fingerstick blood sugar (FSBS) with insulin 3 times a day and for symptoms of high or low FSBS. Review of Resident #5's physician order sheet dated 02/16/23 revealed there was an order for insulin lispro (a short-acting insulin used to treat high blood sugars) inject four times a day before meals and at bedtime per sliding scale: 155-184 = 1 unit; 185-214 = 2 units; 215-244 = 3 units; 245-274 = 4 units. Review of Resident #5's physician order sheet dated 03/15/23 revealed there was an order for insulin lispro four times a day before meals and at bedtime per sliding scale: 155-184 inject 1 unit; 185-214 inject 2 units; 215-244 inject 3 units; 245-274 inject 4 units; 275-304 inject 5 units; 305-334 inject 6 units; 335-364 inject 7 units; over 365 inject 8 units. Review of Resident #5's March 2023 electronic medication administration record (eMAR) revealed: -There was an entry for insulin lispro inject 4 times a day before meals and at bedtime per sliding scale: 155-184 = 1 unit; 185-214 = 2 units; 215-244 = 3 units; 245-274 = 4 units scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was an entry for check FSBS 3 times a day scheduled at 8:00am, 12:00pm, and 4:00pm. -At 8:00am on 03/06/23 2 units of insulin lispro was documented as administered for a FSBS of 229 instead of the 3 units that was ordered. -At 12:00pm on 03/06/23 2 units of insulin lispro was documented as administered for a FSBS of 229 instead of the 3 units that was ordered. -There was an entry for insulin lispro with a start	D 358		

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D 358	Continued From page 48 date of 03/16/23 use as directed per sliding scale if FSBS 155-184 = 1 unit; 185-214 = 2 units; 215-244 = 3 units; 245-274 = 4 units; 275-304 = 5 units; 305-334 = 6 units; 335-364 = 7 units; over 365 = 8 units scheduled for administration at 8:00am, 12:00pm. 4:00pm, and 8:00pm. -There was no space on the entry to record units of insulin administered. -Examples of insulin lispro being documented as administered when the FSBS was less than 155 are as follows: -At 12:00pm on 03/17/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 110. -At 4:00pm on 03/17/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 110. -At 8:00pm on 03/17/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 113. -At 8:00am on 03/20/23 an undetermined amount of insulin lispro was documented as administered for FSBSs of 114. -At 12:00pm on 03/20/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 114. -At 8:00am on 03/22/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 98. -At 8:00am on 03/23/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 143. -At 4:00pm on 03/23/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 153. -At 12:00pm on 03/26/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 145. -At 12:00pm on 03/30/23 an undetermined amount of insulin lispro was documented as	D 358		

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administered for a FSBS of 134.
-Insulin lispro sliding scale was documented as administered 10 times in March 2023 when it was not indicated to be administered.
-Resident #5's FSBSs ranged from 88 to 369 in March 2023.

Review of Resident #5's April 2023 eMAR revealed:
-There was an entry for insulin lispro use as directed per sliding scale if FSBS 155-184 = 1 unit; 185-214 = 2 units; 215-244 = 3 units; 245-274 = 4 units; 275-304 = 5 units; 305-334 = 6 units; 335-364 = 7 units; over 365 = 8 units scheduled for administration at 8:00am, 12:00pm. 4:00pm, and 8:00pm.
-There was no space on the entry to record units of insulin administered.
-Examples of insulin lispro being documented as administered when the FSBS was less than 155 are as follows:
-At 8:00am on 04/06/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 116.
-At 12:00pm on 04/06/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 131.
-At 4:00pm on 04/07/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 93.
-At 8:00pm on 04/16/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 136.
-At 8:00am on 04/17/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 153.
-At 12:00pm on 04/22/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 135.
-At 12:00pm on 04/25/23 an undetermined

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amount of insulin lispro was documented as administered for a FSBS of 154.
-At 8:00pm on 04/29/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 116.
-Insulin lispro sliding scale was documented as administered 8 times in April 2023 when it was not indicated to be administered.
-Resident #5's FSBSs ranged from 88 to 445 in April 2023.

Interview with a medication aide (MA) on 06/01/23 at 11:18am revealed:
-Some residents who were on sliding scale insulin had a place on the eMAR where the units of insulin could be documented, and some did not.
-If there was nowhere to record units of insulin, she just recorded that she administered insulin or if she did not administer the insulin she recorded that she did not administer it and why.
-Resident #5's eMAR did not have a space to record the number of units of sliding scale insulin administered.
-She looked at Resident #5's sliding scale listed on the eMAR to know how much insulin to give for her FSBS.
-On the days she documented that she administered insulin to Resident #5 when it should not have been administered or she administered a different amount than what was ordered she must have read the sliding scale directions wrong.
-She did not think she gave insulin to Resident #5 when she should not have done so but may have clicked the wrong button on the eMAR instead.

Interview with a second MA on 06/01/23 at 3:59pm revealed:
-When she administered sliding scale insulin to Resident #5, she looked at what was on the

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eMAR and gave the amount of insulin ordered based on FSBS results.
-On the days that she documented she administered insulin to Resident #5 when it should have been held, she may have looked at the orders wrong or she may have clicked the wrong button on the eMAR.

Interview with the Administrator on 06/01/23 at 2:36pm revealed:
-She expected MAs to administer insulin to Resident #5 accurately according to what was ordered on her sliding scale.
-It was important for residents to receive the correct amount of insulin as ordered.

Interview with the facility's contracted primary care provider (PCP) on 06/01/23 at 4:32pm revealed:
-It was important to administer sliding scale insulin as ordered.
-Administering insulin to a resident when they were not supposed to receive it could cause their FSBS to go too low.
-Not giving enough insulin to a resident could cause the resident's FSBS to be too high.
-Low FSBS could cause drowsiness or coma and high FSBS could cause long-term effects to a resident's kidneys or eyes.

Attempted interview with Resident #5's PCP on 06/01/23 at 2:22pm was unsuccessful.

4. Review of Resident #11's current FL-2 dated 02/23/23 revealed:
-Diagnoses included vascular dementia, insulin dependent diabetes mellitus (IDDM), hyperlipidemia, history of cerebral vascular accident (CVA), open angle glaucoma, recurrent falls, history of seizures, and history of breast

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cancer.
-She was intermittently disoriented.

Review of Resident #11's physician order dated 03/06/23 revealed there was an order for Novolog FlexPen U-100 Insulin, inject insulin three times a day per sliding scale: 0-200=0 units, 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units to be administered at 8:00am, 12:00pm, and 4:00pm. (Novolog is a rapid-acting insulin used to controll high blood sugar (glucose).

Review of Resident #11's March 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Novolog FlexPen U-100 Insulin three times a day, inject insulin per sliding scale: 0-200=0 units, 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units at 8:00am, 12:00pm, and 4:00pm.
-There was documentation that Novolog insulin was not administered on 03/09/23 at 12:00pm due to being on hold,
-There was documentation that insulin was administered on 03/20/23 at 12:00pm in the upper back arm (no units documented) when the FSBS was 195.
-Insulin should not have been administered based on the ordered sliding scale.

Review of Resident #11's April 2023 eMAR revealed:
-There was an entry for Novolog FlexPen U-100 Insulin three times a day, inject insulin per sliding scale: 0-200=0 units, 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units to be administered at 8:00am, 12:00pm, 4:00pm.
-There was documentation Novolog insulin was administered on 04/11/23 at 4:00pm in the

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abdomen (no units documented) when the FSBS was 188 and on 04/20/23 at 4:00pm in the arm (no units documented) when the FSBS was 198.
-Insulin should not have been administered based on the ordered sliding scale.

Review of Resident #11's May 2023 eMAR revealed:
-There was an entry for Novolog FlexPen U-100 Insulin three times a day, inject insulin per sliding scale (0-200=0 units, 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units to be administered at 8:00am, 12:00pm, 4:00pm.
-There was documentation Novolog insulin was not administered on 05/17/23 at 8:00am, 12:00pm and 4:00pm due to being on hold
-There was documentation the FSBS was 305 on 05/17/23 at 8:00am and 6 units of Novolog insulin was not administered per sliding scale due to being on hold.
-There was documentation the FSBS was 358 on 05/17/23 at 12:00pm and 8 units of Novolog insulin was not administered per sliding scale due to being on hold.
-There was no documentation Novolog insulin was administered on 05/17/23 at 4:00pm due to being on hold.

Interview with the medication aide (MA) on 06/01/23 at 10:30am revealed:
-The "on hold" notation on the eMAR indicated the medication was not available on the cart and had not been received from pharmacy yet.
-Sometimes the facility ran out of blood glucose test strips for testing FSBS.
-Finger stick blood sugars could not be done without the blood glucose test strips.
-Insulin could not be administered without knowing the FSBS value if the resident was on a

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sliding scale.
-She would notify the Administrator when glucose test strips were running low or were out.
-She did not know the process for ordering supplies for the facility.

Interview with the Administrator on 06/01/23 at 2:36pm revealed:
-She expected MAs to administer insulin to residents accurately according to what was ordered on the sliding scale.
-It was important for residents to receive the correct amount of insulin as ordered.

Interview with the facility's contracted primary care provider (PCP) on 06/01/23 at 4:32pm revealed:
-It was important to administer sliding scale insulin as ordered.
-Administering insulin to a resident when they were not supposed to receive it could cause their FSBS to go too low.
-Not giving enough insulin to a resident could cause the resident's FSBS to be too high.
-Low FSBS could cause drowsiness or coma and high FSBS could cause long-term effects to a resident's kidneys or eyes.

5. Review of Resident #13's current FL-2 dated 09/12/22 revealed:
-Diagnoses included cerebral palsy, mood disorder, intellectual disabilities, gait instability, and hypothyroidism.
-He was non-verbal.

Review of Resident #13's physician progress report dated 02/14/23 revealed an order for Xanax 0.25mg, 1 tablet two times a day. (Xanax, also known as Alprazolam, is a medication used to treat anxiety and panic disorders).

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D 358	Continued From page 55 Review of Resident #13's April 2023 electronic administration medication (eMAR) revealed: -There was an order for Xanax 0.25mg, 1 tablet twice a day at 8:00am and 8:00pm. -There was documentation that Xanax 0.25mg, 1 tablet was not administered on 04/10/23 at 8:00am, 04/11/23 at 8:00am and 8:00pm and 04/12/23 at 8:00am with the notation "on hold." -There was no documentation Xanax 0.25mg, 1 tablet was administered on 04/16/23 at 8:00pm (Blank). -Resident #13 missed 5 does of his Xanax during a 4-day period. Review of Resident #13's May 2023 eMAR revealed: -There was an order for Xanax 0.25mg, 1 tablet twice a day at 8:00am and 8:00pm. -There was documentation that Xanax 0.25mg, 1 tablet was not administered on 05/13/23 through 05/15/23 at 8:00am and 8:00pm and 05/16/23 at 8:00am with the notation "on hold." -Resident #13 missed 7 doses of his scheduled Xanax during a 4-day period. Telephone interview with a pharmacist at Resident #13's private pharmacy on 06/02/23 at 11:42am revealed: -This pharmacy was Resident #13's private pharmacy starting 05/15/23. -The resident's Xanax 0.25mg was dispensed for 60 tablets (30-day supply) on 05/15/23 and sent to the facility on 05/16/23. Attempted telephone interview with Resident #13's previous private pharmacist on 06/01/23 at 11:50am was unsuccessful. Observation of Resident #13's medications on	D 358		

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hand on 05/31/23 at 3:00pm revealed 30 tablets were in the bubble card with a dispensed date of 05/15/23.

Interview with Resident #13's family member on 06/02/13 at 2:10pm revealed;
-She was not aware of any issues with the resident's medications.
-She was aware there was a change in his private pharmacy due to the "abrupt" closing of the previous private pharmacy.

Interview with a medication aide (MA) on 06/01/23 at 12:30pm revealed:
-She did not administer Resident #13's Xanax on 05/15/23 and 05/16/23 because it was not available on the medication cart.
-There was a change in pharmacy for Resident #13 that could have been the reason the medication was not on the medication cart yet because a new prescription was required because Xanax was a controlled substance.
-She notified the Administrator that Resident #13's Xanax was not available on the medication cart.
-The notation "on hold" means the medication was not on the medication cart and waiting to be received from pharmacy.

Interview with a second MA on 06/01/23 at 4:30pm revealed:
-She did not administer Resident #13's Xanax on 05/14/23 because it was not available on the medication cart.
-She notified the Administrator that Resident #13's Xanax was not available on the medication cart.
-The notation "on hold" means the medication was not available on the medication cart but was on the way from the pharmacy.

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D 358	Continued From page 57 Interview with the Administrator on 06/01/23 at 4:45pm revealed: -Resident #13's private pharmacy closed abruptly in May 2023 and another private pharmacy was contracted by Resident #13's family. -Because Xanax was a controlled medication, a "hard copy" prescription had to be signed and sent to the new pharmacy which caused a delay. -She did not recall how long it took to receive the prescription. -She expected prescriptions to filled as soon as possible. -She expected medications to be administered as ordered. Interview with the facility's contracted primary care provider (PCP) on 06/01/23 at 4:30pm revealed: -She was not notified Resident #13 did not receive his Xanax as scheduled in April and May. -She expected the medication to be administered as ordered to prevent withdrawal symptoms. -Stopping Resident #13's Xanax abruptly could cause increased agitation, anxiety, heart palpitations and sweating. Based on observations, record reviews, and interviews, it was determined Resident #13 was not interviewable. 6. Review of Resident #8's FL2 dated 11/23/22 revealed: -Diagnoses included hypertension, paroxysmal atrial fibrillation, diabetes, congenital stenosis of aortic, hypothyroidism and chronic kidney value disease. -There was an order for Alprazolam (Xanax) 0.5mg 1 tablet daily at 8:00pm and as needed (PRN).	D 358		

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D 358	Continued From page 58 -Resident #8 was constantly disoriented. Review of a physician order refill request for Resident #8 dated 05/06/23 revealed the facility requested a new prescription for Alprazolam 0.5mg 1 tablet at bedtime. Review of Resident #8's new prescription summary dated 05/24/23 revealed there was an order for Alprazolam 0.5mg at bedtime. Observation of Resident #8's medications on hand on 06/01/23 at 3:46pm revealed the Xanax 0.5mg was not on site to be administered. Review of Resident #8's May 2023 eMAR revealed: -There was an entry to administer Alprazolam 0.5mg one tablet at bedtime. -There was documentation Alprazolam 0.5mg tablet was administered on 05/01/23 through 05/04/23 at 8:00pm. -There was no documentation Alprazolam 0.5mg tablet was administered on 05/05/23 through 05/24/23 at 8:00pm. Review of the May 2023 controlled substance report revealed there was no documentation Alprazolam was administered from 05/05/23 to 05/31/23. Interview with a medication aide (MA) on 06/01/23 at 3:46pm revealed: -She sent a third request to the PCP on 03/18/23 via fax requesting a new order for Alprazolam be sent to the pharmacy. -There was not any Alprazolam 0.5mg currently on site. Based on observations, record reviews, and	D 358		

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interviews, it was determined Resident #8 was not interviewable.

Interview with a second MA on 06/01/23 at 3:51pm revealed:
-Resident #8 had not taken the Alprazolam for over a month.
-Resident #8 had not shown any signs of anxiousness.

Interview with the Administrator on 06/01/23 at 3:00pm revealed:
-Orders were usually sent to the pharmacy by the primary care provider.
-There were times the facility obtained orders and it would take the provider a few days to sign them so there would be a delay in the order being sent.
-New orders were entered onto the eMAR by the pharmacy.
-The former Resident Care Coordinator (RCC) was responsible for ensuring medications were entered as ordered by the provider and approving the order in the eMAR system so that the medication could be administered.
-The former RCC was responsible for ensuring orders were received by the pharmacy and the medications were administered as ordered.
-She had taken on the RCC's duties since she left in April 2023.

Interview with Resident #8's local Pharmacist at the facility's contacted pharmacy on 06/01/23 at 4:10pm revealed:
-The Alprazolam had not been dispensed for May 2023.
-The medication did not have any refills and needed a new prescription.
-There were 30 tablets of Alprazolam 0.5mg dispensed on 01/04/23.
-There were 30 tablets of Alprazolam 0.5mg

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dispensed on 01/30/23.
-There were 30 tablets of Alprazolam 0.5mg dispensed on 02/26/23.
-There were 30 tablets of Alprazolam 0.5mg dispensed on 03/30/23.
-There were a total of 120 tablets Alprazolam 0.5mg dispensed through April 2023.

Interview with Resident #8's PCP on 06/01/23 at 4:32pm revealed:
-She had last seen Resident #8 on 05/03/23.
-She sent a new prescription for Alprazolam 0.5mg.

7. Review of Resident #7's current FL-2 dated 01/04/23 revealed:
-Diagnoses included acquired absence of his left leg below the knee, generalized muscle weakness and abnormal posture.
-He was semi-ambulatory.
-There was no documentation for orientation.

a. Review of Resident #7's physician's order dated 04/05/23 revealed Tylenol 500mg, 2 tablets, was to be administered each night at bedtime.

Review of Resident #7's electronic medication administration record for April 2023 revealed there was no entry for Tylenol 500mg, 2 tablets, to be administered each night at bedtime and no documentation of administration.

Review of Resident #7's electronic medication administration record for May 2023 revealed
-There was an entry for Tylenol 500mg, 2 tablets, to be administered each night at bedtime.
-There was no documentation of administration from 05/01/23 to 05/15/23.
-There was documentation of administration from

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D 358	Continued From page 61 05/16/23 to 05/30/23. Interview with Resident #7 on 05/31/23 at 3:40pm revealed he had pain in both shoulders frequently that had improved since he began getting Tylenol every night before bed along with the cream he received in the morning. Telephone interview with Resident #7's primary care provider (PCP) on 06/01/23 at 4:30pm revealed: -Resident #7 had chronic pain in his shoulders. -She expected orders to be processed within 24 hours. -She expected medications to be administered as ordered to treat the resident promptly and effectively. Interview with a medication aide (MA) on 06/01/23 at 4:50pm revealed: -Resident #7 had shoulder pain. -Resident #7 was prescribed Tylenol scheduled each night that began approximately 2 weeks prior. b. Review of Resident #7's physician's order dated 04/05/23 revealed melatonin 3mg was to be administered each night at bedtime. Review of Resident #7's electronic medication administration record for April 2023 revealed there was no entry for Melatonin 3mg to be administered each night at bedtime and no documentation of administration. Review of Resident #7's electronic medication administration record for May 2023 revealed: -There was no documentation of administration from 05/01/23 to 05/08/23. -There was an entry for melatonin 3mg to be	D 358		

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administered each night at bedtime.
-There was documentation of administration from 05/10/23 to 05/30/23.
-There was documentation melatonin 3mg was not administered on 05/09/23 because it was on hold.

Interview with Resident #7 on 05/31/23 at 3:40pm revealed:
-He sometimes had trouble sleeping at night.
-He thought it was getting better since melatonin was added earlier in the month but he did not know exactly when he began receiving the medication.

Telephone interview with the Pharmacist at facility's contracted pharmacy on 05/31/23 at 11:42am revealed:
-Melatonin was an over the counter medication used to help people fall asleep.
-Resident #7's order for melatonin 3 mg each night dated 04/05/23 was received by fax from the facility on 05/07/23 and dispensed on 05/08/23.
-Orders should be faxed to the pharmacy as soon as possible once it is signed by the provider so that treatment could begin.

Interview with the Administrator on 05/31/23 at 2:02pm revealed:
-When the facility received new orders for a resident the MA that received the orders processed the orders.
-If the orders came from the resident's PCP they were faxed to the resident's pharmacy by the MA.
-If new orders were received after a resident returned from the hospital the new orders were faxed to the resident's pharmacy as well as the resident's PCP.
-MAs were expected to fax the orders to the

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pharmacy as soon as the order was received.
-There was a "bucket system" in place to make sure orders were processed correctly.
-When the orders were received, they were placed into a folder.
-Once the orders were approved and the treatment was started the orders were placed into a different folder.
-The folders were checked daily by the former RCC.
-The RCC was no longer employed at the facility as of 04/18/23 and she had been taking over her duties until a new RCC was hired.

Second interview with the Administrator on 06/01/23 at 3:00pm revealed:
-Orders were usually sent to the pharmacy by the primary care provider.
-There were times the facility obtained orders and it would take the provider a few days to sign them so there would be a delay in the order being sent.
-New orders were entered onto the eMAR by the pharmacy.
-The former Resident Care Coordinator (RCC) was responsible for ensuring medications were entered as ordered by the provider and approving the order in the eMAR system so that the medication could be administered.
-The former RCC was responsible for ensuring orders were received by the pharmacy and the medications were administered as ordered.

Telephone interview with Resident #7's primary care provider (PCP) on 06/01/23 at 4:30pm revealed:
-She expected orders to be processed within 24 hours.
-She expected medications to be administered as order to treat the resident promptly and effectively.

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D 358	Continued From page 64 8. Review of Resident #9's current FL-2 dated 09/14/22 revealed: -Diagnoses included Type II diabetes and lack of coordination. -She was ambulatory and intermittently disoriented. Review of Resident #9's current care plan dated 01/09/23 revealed she required limited assistance from staff for grooming and hygiene. Review of Resident #9's visit note dated 05/07/23 revealed: -Resident #9 had a rash between her legs on the inside of her thighs and complained of pain. -There was documentation the rash was very red in the folds of her groin. -There was an order for Nystatin cream 100,000 units/g to be applied to affected area every 8 hours for 10 days. (Nystatin is a medication used to treat fungal infection such as yeast.) Interview with Resident #9 on 06/01/23 at 2:45pm revealed: -She had a rash on her bottom but she could not remember when it began. -It used to be painful but was it was better. -She could not remember if she received any treatment to the rash. Review of Resident #9's electronic medication administration record (eMAR) for May 2023 revealed there was no entry for Nystatin cream and no documentation of administration. Observation of medications on hand for Resident #9 on 06/01/23 at 5:00pm revealed there was no Nystatin cream available for administration.	D 358		

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D 358	Continued From page 65 Telephone interview with the Pharmacist at Resident #9's contracted pharmacy on 06/01/23 at 4:00pm revealed: -They had not received an order for Nystatin cream for Resident #9. -The medication was used to treat yeast on the skin and a delay in treatment could cause the infection to extend and become worse and the resident would remain uncomfortable for longer. Interview with a medication aide (MA) on 06/01/23 at 4:50pm revealed: -Resident #9 had a rash on her groin area approximately 2 weeks prior. -There had been no scheduled treatment to the area. Telephone interview with Resident #9's primary care provider (PCP) on 06/01/23 at 4:30pm revealed: -She expected orders to be processed within 24 hours. -She expected medications to be administered as order to treat the resident promptly and effectively. -The Nystatin was cream was ordered by a covering provider in her absence but she expected the medication to be administered per the order to treat the yeast infection and decrease the pain and discomfort. Interview with the Administrator on 05/31/23 at 2:02pm revealed: -When the facility received new orders for a resident the MA that received the orders processed the orders. -If the orders came from the resident's PCP they were faxed to the resident's pharmacy by the MA. -If new orders were received after a resident returned from the hospital the new orders were	D 358		

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D 358	Continued From page 66 faxed to the resident's pharmacy as well as the resident's PCP. -MAs were expected to fax the orders to the pharmacy as soon as the order was received. -There was a "bucket system" in place to make sure orders were processed correctly. -When the orders were received, they were placed into a folder. -Once the orders were approved and the treatment was started the orders were placed into a different folder. -The folders were checked daily by the former RCC. -The RCC was no longer employed at the facility as of 04/18/23 and she had been taking over her duties until a new RCC was hired. Second interview with the Administrator on 06/01/23 at 3:00pm revealed: -Orders were usually sent to the pharmacy by the primary care provider. -There were times the facility obtained orders and it would take the provider a few days to sign them so there would be a delay in the order being sent. -New orders were entered onto the eMAR by the pharmacy. -The former Resident Care Coordinator (RCC) was responsible for ensuring medications were entered as ordered by the provider and approving the order in the eMAR system so that the medication could be administered. -The former RCC was responsible for ensuring orders were received by the pharmacy and the medications were administered as ordered. _____ The facility failed to administer medications as ordered to 8 of 12 sampled residents. Resident #2 was sent to the emergency room (ER) for nausea and vomiting and it was found that her seizure medication was at a toxic level which	D 358		

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D 358	Continued From page 67 causes symptoms such as nausea and vomiting and convulsions for which her seizure medication was ordered to be placed on hold. The seizure medication was not placed on hold by the facility and the resident returned to the ER after having a seizure and her medication level was still at a toxic level. Resident #3 was diagnosed with a urinary tract infection (UTI) and placed on an antibiotic and medication used to treat urinary frequency that was caused by the UTI. The medications were not administered for 5 days after being ordered and the resident continued to experience itching and urinary frequency of having to urinate every hour. The failure of the facility resulted in serious physical harm and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/31/23 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JULY 1, 2023.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and	D 367		

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documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, record reviews, and interviews, the facility failed to ensure an accurate electronic medication administration record (eMAR) for 2 of 2 residents sampled with sliding scale insulin orders (#5, #11) as evidenced by the amount of insulin administered per the ordered sliding scale not being documented for residents with insulin dependent diabetes mellitus.

The findings are:

1. Review of Resident #5's current FL-2 dated 02/13/23 revealed diagnoses included insulin dependent type 2 diabetes.

Review of Resident #5's physician order sheet dated 02/16/23 revealed there was an order for insulin lispro (a short-acting insulin used to treat high blood sugars) inject four times a day before meals and at bedtime per sliding scale: 155-184 - 1 unit; 185-214 = 2 units; 215-244 = 3 units; 245-274 = 4 units.

Review of Resident #5's physician order sheet dated 03/15/23 revealed there was an order for

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D 367	Continued From page 69 insulin lispro four times a day before meals and at bedtime per sliding scale: 155-184 inject 1 unit; 185-214 inject 2 units; 215-244 inject 3 units; 245-274 inject 4 units; 275-304 inject 5 units; 305-334 inject 6 units; 335-364 inject 7 units; over 365 inject 8 units. Review of Resident #5's March 2023 electronic medication administration record (eMAR) revealed: -There was an entry for insulin lispro with a start date of 03/16/23 use as directed per sliding scale if FSBS 155-184 = 1 unit; 185-214 = 2 units; 215-244 = 3 units; 245-274 = 4 units; 275-304 = 5 units; 305-334 = 6 units; 335-364 = 7 units; over 365 = 8 units scheduled for administration at 8:00am, 12:00pm. 4:00pm, and 8:00pm. -There was no space on the eMAR to record units of insulin administered. -At 12:00pm on 03/17/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 110. -At 4:00pm on 03/17/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 110. -At 8:00pm on 03/17/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 113. -At 8:00am on 03/20/23 an undetermined amount of insulin lispro was documented as administered for FSBSs of 114. -At 12:00pm on 03/20/23 an undetermined amount of insulin lispro was documented as administered for FSBSs of 114. -At 8:00am on 03/22/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 98. -At 8:00am on 03/23/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 143.	D 367		

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D 367	Continued From page 70 -At 4:00pm on 03/23/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 153. -At 12:00pm on 03/26/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 145. -At 12:00pm on 03/30/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 134. -There was no way to determine how much insulin was administered on these days and times when sliding scale insulin should have been held. -Insulin lispro sliding scale was documented as administered at 8:00am on 03/18/23, 03/21/23,03/24/23, 03/25/23, 03/28/23, and 03/29/23 with no documentation of the number of units administered. -Insulin lispro sliding scale was documented as administered at 12:00pm on 03/18/23, 03/23/23, 03/25/23, 03/29/23, and 03/31/23 with no documentation of the number of units administered. -Insulin lispro sliding scale was documented as administered at 4:00pm on 03/18/23, 03/21/23, and 03/30/23 with no documentation of the number of units administered. -Insulin lispro sliding scale was documented as administered at 8:00pm on 03/18/23, 03/21/23, 03/27/23, and 03/30/23 with no documentation of the number of units administered. -Insulin lispro was documented as administered 29 times in March 2023 with no documentation of the number of units administered. Review of Resident #5's April 2023 eMAR revealed: -There was an entry for insulin lispro use as directed per sliding scale if FSBS 155-184 = 1 unit; 185-214 = 2 units; 215-244 = 3 units; 245-274 = 4 units; 275-304 = 5 units; 305-334 = 6	D 367		

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D 367	Continued From page 71 units; 335-364 = 7 units; over 365 = 8 units scheduled for administration at 8:00am, 12:00pm. 4:00pm, and 8:00pm. -At 8:00am on 04/06/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 116. -At 12:00pm on 04/06/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 131. -At 4:00pm on 04/07/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 93. -At 8:00pm on 04/16/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 136. -At 8:00am on 04/17/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 153. -At 12:00pm on 04/22/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 135. -At 12:00pm on 04/25/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 154. -At 8:00pm on 04/29/23 an undetermined amount of insulin lispro was documented as administered for a FSBS of 116. -There was no way to determine how much insulin was administered on these days and times when sliding scale insulin should have been held. -Insulin lispro sliding scale was documented as administered at 8:00am on 04/01/23, 04/03/23, 04/05/23, 04/08/23, 04/09/23, 04/10/23, 04/11/23, 04/13/23, 04/14/23, 04/15/23, 04/16/23, 04/21/23, 04/22/23, 04/23/23, 04/24/23, 04/25/23, 04/27/23, 04/28/23, and 04/29/23 with no documentation of the number of units administered. -Insulin lispro sliding scale was documented as administered at 12:00pm on 04/01/23, 04/02/23, 04/03/23, 04/04/23, 04/10/23, 04/12/23, 04/15/23,	D 367		

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D 367	Continued From page 72 04/16/23, 04/17/23, 04/21/23, 04/23/23, 04/24/23, 04/27/23, and 04/29/23 with no documentation of the number of units administered. -Insulin lispro sliding scale was documented as administered at 4:00pm on 04/05/23, 04/08/23, 04/12/23, 04/15/23, 04/16/23, 04/19/23, 04/20/23, 04/22/23, 04/24/23, 04/26/23, 04/27/23, and 04/28/23 with no documentation of the number of units administered. -Insulin lispro sliding scale was documented as administered 67 times in March 2023 with no documentation of the number of units administered. Review of Resident #5's May 2023 eMAR revealed: -There was an entry for insulin lispro use as directed per sliding scale if FSBS 155-184 = 1 unit; 185-214 = 2 units; 215-244 = 3 units; 245-274 = 4 units; 275-304 = 5 units; 305-334 = 6 units; 335-364 = 7 units; over 365 = 8 units scheduled for administration at 8:00am, 12:00pm. 4:00pm, and 8:00pm. -Insulin lispro sliding scale was documented as administered at 8:00am on 05/01/23, 05/02/23, 05/03/23, 05/07/23, 05/09/23, 05/11/23, 05/12/23, 05/15/23, 05/16/23, 05/17/23, 05/18/23, 05/19/23, 05/20/23, 05/22/23, 05/23/23, 05/25/23, 05/26/23, and 05/31/23 with no documentation of the number of units administered. -Insulin lispro sliding scale was documented as administered at 12:00pm on 05/01/2, 05/06/23, 05/08/23, 05/10/23, 05/15/23, 05/21/23, and 05/27/23 with no documentation of the number of units administered. -Insulin lispro sliding scale was documented as administered at 4:00pm on 05/02/23, 05/05/23, 05/07/23, 05/08/23, 05/10/23, 05/12/23, 05/15/23, 05/19/23, 05/21/23, and 05/25/23 with no documentation of the number of units	D 367		

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THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 73	D 367		

administered.
-Insulin lispro sliding scale was documented as administered at 8:00pm on 05/02/23, 05/04/23, 05/07/23, 05/11/23, 05/12/23, 05/14/23, 05/20/23, 05/21/23, 05/22/23, and 05/30/23 with no documentation of the number of units administered.
-Insulin lispro sliding scale was documented as administered 44 times in May 2023 with no documentation of the number of units administered.

Refer to interview with a medication aide (MA) on 06/01/23 at 11:18am.

Refer to interview with a second MA on 06/01/23 at 3:59pm.

Refer to interview with the Administrator on 06/01/23 at 2:47am

Refer to interview with a pharmacist at the facility's contracted pharmacy on 06/01/23 at 11:42am.

Refer to interview with the facility's primary care provider (PCP) on 06/01/23 at 4:32pm.

2. Review of Resident #11 current FL-2 dated 02/23/23 revealed:
-Diagnoses included vascular dementia, insulin dependent diabetes mellitus (IDDM), hyperlipidemia, history of cerebral vascular accident (CVA), open angle glaucoma, recurrent falls, history of seizures, and history of breast cancer.
-She was intermittently disoriented.

Review of Resident #11's physician order dated 03/06/23 revealed there was an order for Novolog

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D 367	Continued From page 74 FlexPen U-100 Insulin, inject insulin per sliding scale: 0-200=0 units, 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units to be administered at 8:00am, 12:00pm, and 4:00pm. Review of Resident #11's March 2023 electronic administration record (eMAR) revealed: -There was an order for Novolog FlexPen U-100 Insulin, inject insulin per sliding scale: 0-200=0 units, 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units to be administered at 8:00am, 12:00pm, and 4:00pm. -There was no space on the entry to record units of insulin administered. -There was documentation Novolog insulin was administered at 8:00am on 03/06/23, 03/09/23, 03/10/23, 03/14/23, 03/16/23, 03/18/23, 03/20/23, 03/27/23 and 03/30/23 at 8:00am with no documentation of units administered. -There was documentation Novolog insulin was administered at 12:00pm on 03/06/23, 03/08/23, 03/10/23, 03/11/23, 03/14/23, 03/15/23, 03/18/23, 03/20/23, 03/26/23, 03/27/23, and 03/30/23 with no documentation of units administered -There was documentation Novolog insulin was administered at 4:00pm on 03/06/23, 03/07/23, 03/09/23, 03/10/23, 03/14/23, 03/17/23, 03/20/23, 03/21/23, 03/25/23, 03/27/23, and 03/29/23 with no documentation of units administered. -Novolog insulin was documented as administered 31 times with no documentation of units administered in March 2023. Review of Resident #11's April 2023 eMAR revealed: -There was an order for Novolog FlexPen U-100 Insulin, inject insulin per sliding scale: 0-200=0 units, 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units to be administered at 8:00am, 12:00pm, and 4:00pm.	D 367		

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D 367	Continued From page 75 -There was no space on the entry to record units of insulin administered. -There was documentation Novolog insulin was administered at 8:00am on 04/03/23, 04/04/23, 04/05/23, 04/07/23, 04/08/23, 04/09/23, 04/15/23, 04/17/23, 04/18/23, 04/23/23, 04/25/23, 04/26/23, 04/27/23, 04/29/23 with no documentation of units administered.. -There was documentation Novolog insulin was administered at 12:00pm 04/03/23, 04/04/23, 04/05/23, 04/07/23, 04/10/23, 04/15/23, 04/16/23, 04/17/23, 04/18/23, 04/19/23, 04/22/23, 04/23/23, 04/26/23, 04/28/23, 04/29/23, 04/30/23 with no documentation of units administered. -There was documentation Novolog insulin was administered at 4:00pm on 04/03/23, 04/04/23, 04/07/23, 04/08/23, 04/09/23, 04/11/23, 04/13/23, 04/14/23, 04/15/23, 04/16/23, 04/20/23, 04/25/23, 04/27/23, 04/28/23, 04/20/23, 04/30/23 with no documentation of units documented administered. -Novolog insulin was documented as administered 46 times with no documentation of units administered in April 2023. Review of Resident #11's May 2023 eMAR revealed: -There was an order for Novolog FlexPen U-100 Insulin, inject insulin per sliding scale: 0-200=0 units, 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units to be administered at 8:00am, 12:00pm, and 4:00pm. -There was no space on the entry to record units of insulin administered -There was documentation Novolog insulin was administered at 8:00am on 05/01/23, 05/07/23, 05/09/23, 05/10/23, 05/11/23, 05/12/23, 05/15/23, and 05/18/23 with no documentation of units administered. -There was documentation Novolog insulin was	D 367		

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D 367	Continued From page 76 administered at 12:00pm on 05/01/23, 05/03/23, 05/05/23, 05/07/23, 05/08/23, 05/09/23, 05/10/23, 05/12/23, 05/13/23, 05/16/23 with no documentation of units administered. -There was documentation Novolog insulin was administered at 4:00pm on 05/01/23, 05/03/23, 05/05/23, 05/06/23, 05/08/23, 05/09/23, 05/11/23, and 05/16/23 with no documentation of units administered.. -There were 26 times Novolog insulin was documented as administered in May 2023 with no documentation of units administered. Refer to interview with a medication aide (MA) on 06/01/23 at 11:18am. Refer to interview with a second MA on 06/01/23 at 3:59pm. Refer to interview with the Administrator on 06/01/23 at 2:47am Refer to interview with a pharmacist at the facility's contracted pharmacy on 06/01/23 at 11:42am. Refer to interview with the facility's primary care provider (PCP) on 06/01/23 at 4:32pm. _____ Interview with a medication aide (MA) on 06/01/23 at 11:18am revealed: -Some residents who were on sliding scale insulin had a place on the electronic medication administration record (eMAR) where the units of insulin could be documented, and some did not. -She did not know how the area to record units of insulin was placed on the eMAR or who placed it there. -If there was nowhere to record units of insulin, she just recorded that she administered insulin or	D 367		

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D 367	Continued From page 77 if she did not administer the insulin she recorded that she did not administer it and why. Interview with a second MA on 06/01/23 at 3:59pm revealed she thought the place to record units of insulin on the eMAR was put there by either the previous Resident Care Coordinator (RCC) or the Administrator. Interview with the Administrator on 06/01/23 at 2:47pm revealed: -She did not know why there was no place on Resident #5 and Resident #11's eMARs to record the number of units of insulin that they were administered for their sliding scale coverage. -She was not sure how the place to record units was put on the eMARs or who was responsible for making sure they were on the eMARs. -It was important that the units of insulin administered was recorded so the facility could be certain the residents were receiving the correct dosage of insulin. Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/01/23 at 11:42am revealed it was the facility's responsibility to make sure there was a place on the eMAR to record the units of insulin administered to a resident. Telephone interview with the facility's primary care provider (PCP) on 06/01/23 at 4:32pm revealed: -It was important that there be a place on the eMAR to record how many units of sliding scale insulin residents received to make sure they were receiving the correct dosage of insulin. -It was important to administer sliding scale insulin to residents as ordered. -Not administering enough insulin could cause a resident's FSBS to be too high and administering	D 367		

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D 367	Continued From page 78 too much insulin could cause a resident's FSBS to be too low. -Low FSBSs could cause drowsiness or coma and high FSBSs could cause long-term effects to a resident's kidneys or eyes. _____ The facility failed to to ensure the medication aides were able to document the amount of insulin administered for 2 of 2 sampled residents (#5, #11) who were ordered sliding scale insulin, which resulted in an inaccurate medication administration record. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation _____ That facility provided a plan of protection in accordance with G.S. 131D-21 on 06/01/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 16, 2023.	D 367		