Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076027	A. BUILDING: _____ B. WING _____	08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE	1195 PINEVIEW ROAD RANDLEMAN, NC 27317

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey from August 1, 2023 to August 3, 2023.	D 000		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to serve therapeutic diets as ordered for 2 of 6 sampled residents (#5 and #7) who had orders for a renal diet (#5) and a mechanical soft (MS) diet with chopped meats (#7). The findings are: 1. Review of Resident #5's current FL2 dated 09/13/22 revealed: -Diagnoses included end stage renal disease (ESRD), Parkinson's disease, and hypertension. -There was an order for a regular diet. Review of a signed physician's order for Resident #5 dated 04/06/23 revealed there was an order to change Resident #5's diet order to a renal diet. Review of Resident #5's record revealed that Resident #5's labs were checked on 06/16/23 and his phosphorus level was elevated at 6.6 mg/dL (normal range 2.6 - 4.5 mg/dL for reference).	D 310	Administrator re-trained dietary staff on serving meals according to each therapeutic diet. Dietary Manager/Designee monitored 2 meals per week x3 weeks, then randomly thereafter to ensure all residents are served meals according to resident's physician's order. Administrator will monitor meals randomly to ensure all residents are served meals according to resident's physician's order	9/17/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Penny C. Rogers — TITLE: Administrator — (X6) DATE: 9-1-23

Reviewed and Acknowledged K.M. 09/01/23

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D 310	Continued From page 1 Review of the facility's therapeutic diet list posted in the kitchen updated 07/18/23 revealed Resident #5 was to be served a renal diet. Review of the therapeutic diet menu for renal diets for the lunch meal on 08/01/23 revealed Resident #5 should be served baked fish, a lemon wedge, rice or noodles, confetti coleslaw, a wheat dinner roll, and a fruit basket crumble. Observation of Resident #5's lunch meal service on 08/01/23 from 11:31am to 11:55am revealed: -Resident #5 was served fried fish filet, tartar sauce, steak fries, confetti coleslaw, a wheat dinner roll, and a fruit basket crumble. -Resident #5 consumed 50% of the fried fish filet, 50% of the tartar sauce, 75% of the steak fries, 50% of the confetti coleslaw, 100% of the wheat dinner roll, and 50% of the fruit basket crumble without any difficulties. Review of the therapeutic diet menu for renal diets for the dinner meal on 08/02/23 revealed Resident #5 should be served grilled chicken salad with no tomatoes, salad dressing, creamy pasta salad, and a wheat dinner roll or bread. Observation of Resident #5's dinner meal service on 08/02/23 from 3:45pm to 4:02pm revealed: -Resident #5 was served ham salad with lettuce, cucumbers, onions, and cheese topped with French dressing; pasta salad, 3 low sodium crackers, and 2 slices of cantaloupe. -Resident #5 consumed 50% of the ham salad, 0% of the pasta salad, 100% of the low sodium crackers, and 100% of the cantaloupe. Telephone interview with Resident #5's primary care provider (PCP) on 08/03/23 at 10:10am revealed:	D 310		

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D 310	Continued From page 2 -Resident #5 was on a renal diet because he had ESRD and was on dialysis. -No one from the facility contacted her to let her know that Resident #5 was not served the ordered renal diet. -Resident #5 not being served a renal diet could affect his labs for dialysis, but she was not sure and would defer to a specialist. -She expected the facility to follow all provider orders, to include therapeutic diets served as ordered. Interview with Resident #5 on 08/02/23 at 9:00am revealed: -He knew he was supposed to be on a renal diet. -His dialysis schedule was every Monday, Wednesday, and Friday. -He normally ate breakfast on dialysis days before leaving for the dialysis center around 9:45am and ate dinner after returning to the facility around 3:45pm. -He knew he was not supposed to eat certain foods. -He was served the same food as all the other residents. -His providers tried to regulate his potassium and phosphorus levels with binders that were administered by facility staff with meals. -He was served a fried fish patty during the lunch meal service on 08/01/23 instead of baked fish. Interview with Resident #5's family member on 08/03/23 at 12:40pm revealed: -She had made the decision to allow Resident #5 to eat regular foods sometimes to increase his quality of life. -She knew that Resident #5 was not always served a strict renal diet. -She watched his lab results which were done monthly.	D 310		

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D 310	Continued From page 3 -She tried to moderate and reason with Resident #5 as far as diet choices and she made sure that he was administered binder medications with meals and snacks. Telephone interview with the registered dietician (RD) at Resident #5's dialysis center on 08/03/23 at 10:50am revealed: -Resident #5 received dialysis treatments every Monday, Wednesday, and Friday. -Resident #5 had received dialysis treatments since 2014. -If Resident #5 was not being served a renal diet as ordered by the provider, it could affect his labs, including sodium, potassium, and phosphorus levels. -The only elevated lab result for Resident #5 on his last lab result was phosphorus. Telephone interview with the charge nurse at Resident #5's dialysis center on 08/03/23 at 10:55am revealed: -The facility had contacted the dialysis center and informed them that Resident #5 was not being served a strict renal diet. -Resident #5 and his family member had made the decision to allow him to eat "off diet" for more quality of life rather than adhere to a strict renal diet. -Resident #5's phosphorus level was elevated this month when lab results were last drawn. -Resident #5's diet would not affect the dialysis process or treatments. Interview with the Dietary Manager (DM) on 08/03/23 at 9:15am revealed: -She knew that Resident #5 was to be served a renal diet. -She tried to follow a renal diet, but she also went by Resident #5's food preferences and what	D 310		

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D 310	Continued From page 4 Resident #5's family member had stated about allowing him more freedom in food choices. -She did not always go by the therapeutic menu for Resident #5's renal diet. -She served fried fish instead of baked fish to Resident #5 because it was breaded fish when it was delivered. -She was not aware that Resident #5 was to be served a lemon wedge instead of tartar sauce and rice or noodles instead of steak fries for the lunch meal service on 08/01/23. -She served Resident #5's food based on the regular diet menu for the lunch meal service on 08/01/23. -She substituted ham salad for grilled chicken salad for Resident #5's dinner meal on 08/02/23 because she only had fried chicken tenders and did not have grilled chicken available. Attempted telephone interview with the Resident Care Coordinator (RCC) on 08/03/23 at 9:30am unsuccessful. Interview with the Administrator on 08/03/23 at 12:15pm revealed: -Resident #5 was ordered a renal diet because he had ESRD and was on dialysis. -She was aware Resident #5 was not being served a renal diet as ordered by the provider. -Resident #5 had previously complained about the food and it seemed that his quality of life had decreased. -Resident #5 was on dialysis and had been for a long time and she wanted Resident #5 to have the food that he wanted. -The fried fish that was served to Resident #5 was breaded when it arrived from the food truck delivery and since the fish was breaded it had to be served fried.	D 310		

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D 310	Continued From page 5 Refer to the interview with a personal care aide (PCA) on 08/03/23 at 8:45am. Refer to the interview with the Dietary Manager (DM) on 08/03/23 at 9:20am. Refer to the interview with the Administrator on 08/03/23 at 12:20pm. 2. Review of Resident #7's current FL2 dated 03/01/23 revealed: -Diagnoses included dementia, congestive heart failure, and hypertension. -There was an order for a regular diet with chopped meats. Review of a signed physician's order for Resident #7 dated 03/21/23 revealed there was an order to change Resident #7's diet order to a MS/chopped meats diet. Review of the facility's therapeutic diet list posted in the kitchen updated 07/18/23 revealed Resident #7 was to be served regular diet with chopped meats which did not match her diet order. Review of the therapeutic diet menu for MS diets for the lunch meal on 08/01/23 revealed Resident #7 should be served baked fish, tartar sauce, diced potatoes, braised cabbage, a wheat dinner roll, and a fruit basket crumble. Observation of Resident #7's lunch meal service on 08/01/23 from 11:50am to 12:07pm revealed: -Resident #7 was served fried fish filet, tartar sauce, steak fries, confetti coleslaw, a wheat dinner roll, and a fruit basket crumble. -Resident #7 consumed 25% of the fried fish filet, 50% of the tartar sauce, 50% of the steak fries,	D 310		

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D 310	Continued From page 6 50% of the confetti coleslaw, 100% of the wheat dinner roll, and 50% of the fruit basket crumble without any difficulties. Review of the therapeutic diet menu for MS diets for the lunch meal on 08/02/23 revealed Resident #7 should be served ground baked pork chop, northern beans with onions, a vegetable blend, and a wheat dinner roll. Observation of Resident #7's lunch meal service on 08/02/23 from 11:26am to 11:47am revealed: -Resident #7 was served chopped baked pork chop, northern beans with onions, a vegetable blend, and a wheat dinner roll. -Resident #7 consumed 25% of the lunch meal without any difficulties. Telephone interview with Resident #7's primary care provider (PCP) on 08/03/23 at 10:15am revealed: -She could not remember why she had changed Resident #7's diet order to a MS/chopped meats diet. -She was not aware Resident #7 was served a regular diet with chopped meats instead of the ordered MS/chopped meats diet since 03/21/23. -She expected the facility to follow all provider orders, to include serving therapeutic diets as ordered. Based on observations, interviews, and record review it was determined that Resident #7 was not interviewable. Interview with Resident #7's family member on 08/02/23 at 3:35pm revealed: -She did not know if Resident #7 was served a special diet. -She had not observed one of Resident #7's	D 310		

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D 310	Continued From page 7 meals recently at the facility. -Resident #7 had never had any issues with swallowing or eating meals. Attempted telephone interview with the Resident Care Coordinator (RCC) on 08/03/23 at 9:30am unsuccessful. Interview with the Dietary Manager (DM) on 08/03/23 at 9:15am revealed: -She did not know Resident #7's diet was changed to a MS/chopped meats diet on 03/21/23. -The RCC normally told the DM when there was a new diet order or when a diet order was changed. -She did not know Resident #7 should have been served diced potatoes instead of steak fries and braised cabbage instead of confetti coleslaw during the lunch meal service on 08/01/23. -She did not know that the baked pork chop served to Resident #7 during the lunch meal on 08/02/23 should have been ground instead of chopped into pieces because she did not know Resident #7 was ordered a MS/chopped meats diet. -If she knew that Resident #7 was ordered a MS/chopped meats diet she would have served Resident #7 based on the regular menu on 08/02/23, but she would have ground her food up so that it was MS consistency. Interview with the Administrator on 08/03/23 at 12:16pm revealed: -The DM would not have known that Resident #7's diet order was changed to a MS/chopped meats diet if she was not told by the RCC. -She was not aware Resident #7 was not served a MS/chopped meats diet. Refer to the interview with a personal care aide	D 310		

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D 310	Continued From page 8 (PCA) on 08/03/23 at 8:45am. Refer to the interview with the Dietary Manager (DM) on 08/03/23 at 9:20am. Refer to the interview with the Administrator on 08/03/23 at 12:20pm. Interview with a PCA on 08/03/23 at 8:45am revealed: -PCAs helped serve food to the residents on the weekends. -The cook or DM let PCAs know what residents were supposed to be served. -She had completed online modules related to food service training. -The cook or DM cooked and plated the food and the PCAs brought the residents' plates to their tables. Interview with the DM on 08/03/23 at 9:20am revealed: -She knew what food to prepare for the residents based on the menus. -She used therapeutic menus for guidance to prepare food. -The therapeutic diet list was posted in the kitchen. -There was always a cook for all three meals. -She or the cook prepared therapeutic diets. -She was responsible to ensure that food was prepared correctly according to the menus. -She was responsible for training dietary staff and she had been the DM for 2 years. -She prepared and plated the food and a PCA or dietary aide took the residents' food to their tables. -Staff were dependent on her or the cook to know what food to serve to the residents and she told staff which food plates were for which residents.	D 310		

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D 310	Continued From page 9 Interview with the Administrator on 08/03/23 at 12:20pm revealed: -The cook or DM was expected to prepare, cook, and serve the food according to diet orders. -Dietary staff were trained by the DM. -The DM was responsible for and ordered food twice a week. -The DM knew what to order based on the menus. -The DM was responsible for serving diets as ordered by the provider. -The Resident Care Coordinator (RCC) was responsible for letting the DM know if there were new diet orders or any diet order changes ordered by the provider.	D 310		
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 B VIOLATION Based on observations, record reviews and interviews, the facility failed to administer medications as ordered for 1 of 4 residents (#6) observed during the medication pass who had orders for a vitamin supplement and an antihistamine; and for 1 of 5 sampled residents	D 358		

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D 358	Continued From page 10 (#3) for record review who had an order for a high-risk blood thinning medication. The findings are: 1. Review of Resident #3's current FL2 dated 03/01/23 revealed: -Diagnoses included Alzheimer's disease, major neurocognitive disorder, and mechanical aortic valve replacement. -There was an order for warfarin (a blood thinning medication used to prevent the formation of blood clots) 1mg, take one-half tablet daily. -There was an order for warfarin 5mg, take one tablet daily. Review of Resident #3's laboratory result dated 05/26/23 revealed her international normalized ratio (INR is a blood test that evaluates how quickly blood forms a clot) was 1.4 (goal range for having a history of mechanical heart valve placement was 2.5 to 3.5). Review of Resident #3's physician order dated 05/26/23 revealed an order to discontinue the previous warfarin order and start warfarin 3.5mg daily; recheck INR in one week. Review of Resident #3's laboratory result dated 06/02/23 revealed her INR was 2.3. Review of Resident #3's physician order dated 06/02/23 revealed an order to continue current dose of warfarin and recheck INR in one week. Review of Resident #3's laboratory result dated 06/09/23 revealed her INR was 1.2. Review of Resident #3's physician order dated 06/09/23 revealed an order to discontinue the	D 358	Administrator audited medications to assure all medications were in the facility available to administer. Administrator/Pharmacy Staff retrained medication aides on medication administration and medications errors. For any med error identified, the PCP will be notified and med error report completed. Administrator/RCC will observe a minimum of two medication passes weekly x4, will observe a minimum of 3 medication passes monthly x3 and then randomly thereafter to ensure medication is administered as ordered by the physician.	9/17/2023

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D 358	Continued From page 11 previous warfarin order and start warfarin 4mg daily; recheck INR in one week. Review of Resident #3's laboratory result dated 06/14/23 revealed her INR was 1.4. Review of Resident #3's physician order dated 06/14/23 revealed an order to continue current dose of warfarin and recheck INR in one week. Review of Resident #3's laboratory result dated 06/21/23 revealed her INR was 1.9. Review of Resident #3's physician order dated 06/21/23 revealed an order to continue current dose of warfarin and recheck INR in one week. Review of Resident #3's laboratory result dated 06/28/23 revealed her INR was 1.3. Review of Resident #3's physician order dated 06/28/23 revealed an order to continue current dose of warfarin and recheck INR in one week. Review of Resident #3's June 2023 electronic medication administration record (eMAR) revealed: -There was an entry for warfarin 1mg take 1 tablet daily along with a 2.5mg tablet to equal dose of 3.5mg daily scheduled at 5:00pm; there was an order start date of 05/26/23. -There was an entry for warfarin 2.5mg take 1 tablet daily along with 1mg tablet to equal dose of 3.5mg daily scheduled at 5:00pm; there was an order start date of 05/26/23. -There was documentation warfarin 3.5mg was administered daily from 06/01/23 through 06/30/23. -There was no entry for warfarin 4mg dated 06/09/23 or documentation warfarin 4mg was	D 358		

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D 358	Continued From page 12 administered starting on 06/09/23 as ordered. Review of Resident #3's laboratory result dated 07/05/23 revealed her INR was 1.1. Review of Resident #3's physician order dated 07/05/23 revealed an order to discontinue the previous warfarin order and start warfarin 4mg daily; recheck INR in one week. Review of Resident #3's laboratory result dated 07/12/23 revealed her INR was 1.1. Review of Resident #3's physician order dated 07/12/23 revealed an order to discontinue previous warfarin order and start warfarin 5mg daily; recheck INR in one week. Review of Resident #3's laboratory result dated 07/18/23 revealed her INR was 1.7. Review of Resident #3's physician order dated 07/18/23 revealed an order to discontinue the previous warfarin order and start warfarin 5.5mg on Monday, Wednesday, Friday, and take warfarin 5mg Tuesday, Thursday, Saturday and Sunday; recheck INR in one week. Review of Resident #3's laboratory result dated 07/26/23 revealed her INR was 4.6. Review of Resident #3's physician order dated 07/27/23 revealed an order to hold warfarin 07/27/23 and recheck INR 07/28/23. Review of Resident #3's laboratory result dated 07/28/23 revealed her INR was 3.9. Review of Resident #3's physician order dated 07/28/23 revealed an order to start warfarin 4mg	D 358		

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NORTH POINTE	1195 PINEVIEW ROAD RANDLEMAN, NC 27317

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 13 daily on 07/30/23 and recheck INR on 08/02/23. Review of Resident #3's July 2023 eMAR revealed: -There was an entry dated 05/26/23 for warfarin 1mg take 1 tablet daily along with a 2.5mg tablet to equal dose of 3.5mg daily scheduled at 5:00pm with a discontinue date of 07/05/23. -There was an entry dated 05/26/23 for warfarin 2.5mg take 1 tablet daily along with 1mg tablet to equal dose of 3.5mg daily scheduled at 5:00pm with a discontinue date of 07/05/23. -There was documentation warfarin 3.5mg was administered daily from 07/01/23 through 07/04/23. -There was an entry dated 07/05/23 for warfarin 4mg, take 1 tablet daily scheduled at 5:00pm with a discontinue date of 07/12/23. -There was documentation warfarin 4mg was administered daily from 07/05/23 through 07/11/23. -There was an entry dated 07/12/23 for warfarin 5mg, take 1 tablet daily scheduled at 8:00am with a discontinue date of 07/18/23. -There was documentation warfarin 5mg was administered daily on 07/13/23, 07/14/23 and 07/15/23. -There was no documentation warfarin 5mg was administered 07/12/23, 07/16/23 or 07/17/23 as ordered; there was documentation warfarin 5mg was not administered on 07/16/23 and 07/17/23 due to order change but there was no documentation of what the order changed to. -There was an entry dated 07/18/23 for warfarin 5mg take 1 tablet daily scheduled at 5:00pm with a discontinue date of 07/28/23. -There was documentation warfarin 5mg was administered daily from 07/18/23 through 07/26/23. -There was an entry dated 07/18/23 for warfarin	D 358		

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D 358	Continued From page 14 1mg take 0.5 tablet on Monday, Wednesday, and Friday with the 5mg dose for a total of 5.5mg, scheduled at 5:00pm with a discontinue date of 07/28/23. -There was documentation warfarin 0.5mg was administered 07/19/23, 07/21/23, 07/24/23, and 07/26/23. -There was a second entry for warfarin 4mg take 1 tablet daily scheduled at 5:00pm; there was an order start date of 07/31/23. -There was documentation warfarin 4mg was administered on 07/31/23. -There was no documentation warfarin 4mg was administered 07/30/23 as ordered. Review of Resident #3's laboratory result dated 08/01/23 revealed her INR was 4.5. Observation of medication on hand for Resident #3 on 08/01/23 revealed there was one medication card for warfarin 4mg tablets with a dispensed date of 07/28/23, and 14 out of 15 dispensed tablets remaining. Interview with a medication aide (MA) on 08/01/23 revealed: -When Resident #3's warfarin order changed, the "old" warfarin dosage cards were returned to the pharmacy. -The MAs only administered warfarin on the days it appeared on the eMAR as a medication that was due. -The Resident Care Coordinator (RCC) was responsible for ensuring the eMAR was accurate after Resident #3's warfarin orders changed, and for checking the medication cart for the availability of the new warfarin dose. -If the RCC was not at the facility, the supervisor was responsible for ensuring Resident #3's eMAR was accurate for that day's warfarin dose	D 358		

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D 358	Continued From page 15 and for ensuring the correct dose of warfarin tablets were delivered from the pharmacy. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/02/23 at 11:00am revealed: -On 05/26/23, the pharmacy dispensed a 24-day's supply of warfarin 2.5mg tablets and 1mg tablets to equal 3.5mg daily. -On 06/12/23, the pharmacy dispensed a 28-day's supply of warfarin 2.5mg tablets and 1mg tablets to equal 3.5mg daily. -The pharmacy had not received an order dated 06/09/23 to increase Resident #3's warfarin dose to 4mg daily. -On 07/05/23, Resident #3's warfarin order changed to 4mg daily, so the pharmacy dispensed a 12-day's supply of warfarin 4mg tablets to get to the next cycle-fill date. -On 07/12/23, Resident #3's warfarin order increased to 5mg daily, so the pharmacy dispensed a 5-day's supply of warfarin 5mg. -On 07/13/23, the pharmacy dispensed a 28-day's supply of warfarin 5mg tablets. -On 07/18/23, Resident #3's warfarin order increased to 5.5mg on Monday, Wednesday, and Friday, and 5mg on Tuesday, Thursday, Saturday and Sunday, so the pharmacy dispensed eleven-and-a-half, half-tablets of warfarin 1mg tablets to add to the current supply of warfarin 5mg tablets already at the facility. -On 07/28/23, Resident #3's warfarin order changed to warfarin 4mg starting on 07/30/23, so the pharmacy dispensed 15 warfarin 4mg tablets on 07/28/23. Telephone interview with Resident #3's primary care provider (PCP) on 08/03/23 at 10:00am revealed: -She managed Resident #3's INR and warfarin	D 358		

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D 358	Continued From page 16 dosing. -Resident #3's diagnosis for taking warfarin was mechanical valve replacement. -Resident #3's goal range for her INR value was 2.5 to 3.5. -She was not aware that Resident #3's warfarin was never increased from 3.5mg to 4mg on 06/09/23 as she had ordered. -Her subsequent warfarin dosing was based on the assumption that Resident #3 was taking 4mg daily as ordered, so when she had ordered the facility to continue Resident #3's current dose of warfarin she had wanted them to be administering 4mg daily, not 3.5mg daily. -On 07/05/23 when she received Resident #3's INR value of 1.1, the staff had told her that the current warfarin dose was 3.5mg so she increased the dose to 4mg daily. -She was not aware at the time, but the facility was not administering Resident #3's warfarin as ordered so she kept changing the warfarin dose based on what Resident #3 was supposed to be taking. -She was not aware that Resident #3 did not receive any dose of warfarin on 07/12/23, 07/16/23 or 07/17/23, which could have resulted in her INR value remaining below her goal range. -Resident #3 did not have any other medication order changes or antibiotic use between 07/18/23 and 07/26/23 when her INR increased from 1.7 to 4.6, so it was likely the INR increased so much because she had not been receiving warfarin as ordered, so when she increased the dose on 07/18/23, it was too much of an increase. -She was not aware that Resident #3 did not receive any dose of warfarin on 07/30/23. -The only reason for the facility to not administer a dose of warfarin to Resident #3 was if she had ordered for the warfarin to be held. -If the facility could not reach her to obtain new	D 358		

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D 358	Continued From page 17 warfarin dosing based off Resident #3's INR result for that day, the facility should be contacting the on-call provider for guidance. -She expected the staff to administer warfarin every day and exactly how she ordered it since it was a high-risk medication. -If Resident #3's INR dropped too low or increased too high it placed her at risk for either blood clots, or bleeding. Telephone interview with the Supervisor at the facility's contracted pharmacy on 08/03/23 at 10:50am revealed: -Either the pharmacy or the facility could enter medication orders on the eMAR. -If the pharmacy entered a medication order on the eMAR, someone at the facility would have to approve the order before it became active on the eMAR. -Resident #3's warfarin order dated 07/28/23 was entered into the eMAR to begin warfarin 4mg starting on 07/30/23, but if the medication did not populate as being due on the eMAR 07/30/23, the facility might have changed the order on their end. Interview with the Administrator on 08/03/23 at 11:40am revealed: -The RCC was responsible for reviewing Resident #3's INR results and notifying the PCP. -The RCC was responsible for faxing new warfarin orders from the PCP to the pharmacy, and ensuring they were accurate on the eMAR and the medication was available for administration. -If the RCC was not at the facility, the Supervisor was responsible for texting the RCC Resident #3's INR result, then the RCC would contact the PCP for the new warfarin order, and then the Supervisor was responsible for faxing any new	D 358		

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D 358	Continued From page 18	D 358		

warfarin dose orders to the pharmacy.
-The RCC was the only staff responsible for entering medication orders on the eMAR for Resident #3's warfarin.
-The pharmacy did not enter Resident #3's warfarin orders on the eMAR.
-She did not know why Resident #3's order to increase her warfarin dose from 3.5mg to 4mg daily was missed.
-She did not know that Resident #3 was not administered warfarin on 07/12/23, 07/16/23, 07/17/23, or 07/30/23.
-The RCC did audits of the eMARs, but she did not know what she checked during her audits.
-She expected Resident #3's warfarin to be administered as ordered with no gaps between the start and discontinue dates on the eMAR.
-She expected the MAs to administer warfarin to Resident #3 every day as ordered by the PCP unless there was an order to hold the warfarin.

Based on record review and attempted interview, it was determined Resident #3 was not interviewable.

Attempted telephone interview with the MA who documented warfarin as not administered on 07/16/23 and 07/17/23 on 08/02/23 at 2:20pm was unsuccessful.

Attempted telephone interview with the RCC on 08/03/23 at 9:30am was unsuccessful.

2. The medication error rate was 6% as evidenced by 2 errors out of 31 opportunities during the 8:00am medication pass on 08/02/23.

Review of Resident #6's current FL2 dated 12/29/22 revealed diagnoses included osteoporosis, hyperlipidemia, type 2 diabetes,

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D 358	Continued From page 19 and hypertension. a. Review of Resident #6's current FL2 dated 12/29/22 revealed there was an order for vitamin D3 (a vitamin D supplement) 2,000 units daily. Observation of the morning medication pass on 08/02/23 at 8:20am revealed: -The medication aide (MA) removed 9 bottles of medications from the medication cart and compared each medication bottle label to the medications due for administration on the electronic medication administration record (eMAR). -The MA administered 12 tablets to Resident #6 with a cup of water and observed Resident #6 taking and swallowing each medication. -The MA did not administer the vitamin D supplement because it was not available in the medication cart for administration. Review of Resident #6's August 2023 eMAR revealed: -There was an entry for vitamin D 2,000 units take 1 tablet daily, family provides and scheduled at 8:00am. -There was documentation vitamin D was administered on 08/01/23. -There was no documentation that vitamin D was administered on 08/02/23. Observation of medication on hand for Resident #6 on 08/02/23 at 8:25am revealed there was no vitamin D supplements available for administration. Interview with the MA on 08/02/23 at 8:26am revealed: -Resident #6's vitamin D supplement came from her chosen pharmacy.	D 358		

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D 358	Continued From page 20 -She did not document the calls to Resident #6's family to let them know Resident #6 was running low on a medication and that it needed to be reordered from the pharmacy. -The Resident Care Coordinator (RCC) was responsible for calling Resident #6's pharmacy to request a refill, but she did not know if the RCC was aware that Resident #6 ran out of vitamin D. -The MAs were supposed to request medication refills when the quantity of doses remaining was 10 or fewer. Interview with Resident #6 on 08/02/23 at 1:30pm revealed: -She was not aware she had ran out of vitamin D because the MA did not tell her. -She thought her family purchased the vitamin D supplement over-the-counter. -If she was running low on a medication, the staff were supposed to call her family so they could purchase the medication and bring it to the facility. -If she ran low on a medication that came from her pharmacy, she thought the RCC called the pharmacy and reordered it for her. Telephone interview with Resident #6's responsible person on 08/02/23 at 2:00pm revealed: -He had not received any notification from the facility that Resident #6 was running low or had ran out of the vitamin D supplement. -He expected the facility to contact him at least a week in advance about a medication running low so that he had time to purchase the medication and bring it to the facility before Resident #6 ran out. Telephone interview with Resident #6's primary care provider (PCP) on 08/02/23 at 10:00am	D 358		

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D 358	Continued From page 21 revealed: -If a medication was due on a medication pass, she expected the MAs to administer it as ordered. -She expected the MAs to reorder medications prior to them running out so that Resident #6 would not miss any doses of her ordered medication. Interview with the Administrator on 08/03/23 at 11:40am revealed: -She was not aware Resident #6 ran out of vitamin D. -She expected the MAs to request refills when the quantity medication was down to a 7-day's supply remaining. -The MAs were supposed to call Resident #6's responsible person to request the refill at least one week in advance to give him time to obtain the medication and bring it to the facility. -She and the RCC completed medication cart audits monthly. -During the medication cart audits she looked to see that all ordered medications were available on the medication cart; she sometimes checked the quantity of medication remaining, but ultimately it was the MA's responsibility to notify Resident #6's family of needed refills. Attempted telephone interview with the MA who worked on 08/01/23 at 2:20pm was unsuccessful. Attempted telephone interview with the RCC on 08/03/23 at 9:30am was unsuccessful. b. Review of Resident #6's current FL2 dated 12/29/22 revealed there was an order for Zyrtec (an antihistamine medication) 10mg daily. Observation of the morning medication pass on 08/02/23 at 8:20am revealed:	D 358		

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D 358	Continued From page 22 -The medication aide (MA) removed 9 bottles of medications from the medication cart and compared each medication bottle's label to the medications due for administration on the electronic medication administration record (eMAR). -The MA administered 12 tablets to Resident #6 with a cup of water and observed Resident #6 taking and swallowing each medication. -The MA did not administer Zyrtec 10mg tablet because it was not available in the medication cart for administration. Review of Resident #6's August 2023 eMAR revealed: -There was an entry for Zyrtec 10mg daily scheduled at 8:00am. -There was documentation Zyrtec was administered on 08/01/23. -There was no documentation that Zyrtec was administered on 08/02/23. Observation of medication on hand for Resident #6 on 08/02/23 at 8:25am revealed there was no Zyrtec available for administration. Interview with the MA on 08/02/23 at 8:26am revealed: -Resident #6's Zyrtec was brought in from her family. -She did not document the calls to Resident #6's family to let them know that Resident #6 was running low on a medication. -She did not know if any of the MAs had contacted Resident #6's family to request a refill of Resident #6's Zyrtec. -The MAs were supposed to request medication refills when the quantity of doses remaining was 10 or fewer.	D 358		

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D 358	Continued From page 23 Interview with Resident #6 on 08/02/23 at 1:30pm revealed: -She was not aware that she had ran out of Zyrtec, because the MA did not tell her. -She thought her Zyrtec came from her pharmacy. -If she was running low on a medication, the staff were supposed to call her family. -If she ran low on a medication that came from her pharmacy, she thought the Resident Care Coordinator (RCC) called the pharmacy and reordered it for her. Telephone interview with Resident #6's responsible person on 08/02/23 at 2:00pm revealed: -He had not received any notification from the facility that Resident #6 was running low or had ran out of Zyrtec. -He expected the facility to contact him at least a week in advance about a medication running low so that he had time to purchase the medication and bring it to the facility before Resident #6 ran out. -The facility was supposed to reach out to Resident #6's pharmacy to request the refills that came from the pharmacy. Telephone interview with Resident #6's primary care provider (PCP) on 10:00am revealed: -She did not know Resident #6's diagnosis for having Zyrtec ordered for her; she thought she was admitted to the facility already taking that medication. -She expected the MAs to reorder medications prior to them running out so that Resident #6 would not miss any doses of her ordered medication. Interview with the Administrator on 08/03/23 at	D 358		

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D 358	Continued From page 24 11:40am revealed: -She was not aware that Resident #6 ran out of Zyrtec. -She expected the MAs to request refills when the quantity was down to a 7-day's supply remaining. -The MAs were supposed to call Resident #6's responsible person to request the refill at least one week in advance to give him time to obtain the medication and bring it to the facility. -She and the RCC completed medication cart audits once per month. -During the medication cart audits she looked to see that all ordered medications were available on the medication cart; she sometimes checked the quantity of medication remaining but ultimately it was the MA's responsibility to notify Resident #6's family of needed refills. Attempted telephone interview with the MA who worked on 08/01/23 at 2:20pm was unsuccessful. Attempted telephone interview with the RCC on 08/03/23 at 9:30am was unsuccessful. _____ The facility failed to ensure medications were administered as ordered for Resident #3 who had an order to increase the dose of a high-risk blood thinning medication that was never increased, placing the resident at risk for developing blood clots, and who had missed doses of her blood thinner which resulted in inaccurate dosing of the medication which could have contributed to an increase in her INR value which placed the resident at risk for bleeding. This failure was 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. 131D-34 on 08/03/23 for this violation.	D 358		

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D 358	Continued From page 25 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, SEPTEMBER 17, 2023.	D 358		