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RICHMOND HILL ASSISTED LIVING # 1	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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D 000	Initial Comments The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted an annual and follow-up survey and complaint investigation on 09/13/23-09/15/23. The complaint investigation was initiated by the Buncombe County Department of Social Services on 09/07/23.	D 000		
D 156	10A NCAC 13F .0503 Medication Administration Competency 10A NCAC 13F .0503 Medication Administration Competency (a) The competency evaluation for medication administration required in Rule .0403 of this Subchapter shall consist of a written examination and a clinical skills evaluation to determine competency in the following areas: (1) medical abbreviations and terminology; (2) transcription of medication orders; (3) obtaining and documenting vital signs; (4) procedures and tasks involved with the preparation and administration of oral (including liquid, sublingual and inhaler), topical (including transdermal), ophthalmic, otic, and nasal medications; (5) infection control procedures; (6) documentation of medication administration; (7) monitoring for reactions to medications and procedures to follow when there appears to be a change in the resident's condition or health status based on those reactions; (8) medication storage and disposition; (9) regulations pertaining to medication administration in adult care facilities; and (10) the facility's medication administration policy and procedures (b) An individual shall score at least 90% on the written examination which shall be a standardized	D 156		

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examination established by the Department.
(c) Verification of an individual's completion of the written examination and results can be obtained at no charge on the North Carolina Adult Care Medication Aide Testing website at https://mats.ncdhhs.gov/test-result.
(d) The clinical skills validation portion of the competency evaluation shall be conducted by a registered nurse or a licensed pharmacist who has a current unencumbered license in North Carolina. The registered nurse or licensed pharmacist shall conduct a clinical skills validation for each medication administration task or skill that will be performed in the facility. Competency validation by a registered nurse is required for unlicensed staff who perform any of the personal care tasks related to medication administration listed in Subparagraphs (a)(4), (a)(7), (a)(11), (a)(14), and (a)(15) as specified in Rule .0903 of this Subchapter.
(e) The Medication Administration Skills Validation Form shall be used to document successful completion of the clinical skills validation portion of the competency evaluation for those medication administration tasks to be performed in the facility employing the medication aide. The form requires the following:
(1) name of the staff and adult care home;
(2) satisfactory completion date of demonstrated competency of task or skill with the instructor's initials or signature;
(3) if staff needs more training on skills or tasks, it should be noted with the instructor's signature; and
(4) staff and instructor signatures and date after completion of tasks.
Copies of this form and instructions for its use may be obtained at no cost on the Adult Care Licensure website,

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https://info.ncdhhs.gov/dhsr/acls/pdf/medchklst.pdf. The completed form shall be maintained and available for review in the facility and is not transferable from one facility to another.

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

Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff who administered medications had successfully passed the written state medication administration examination (Staff A) and completed the 5, 10, or 15-hour medication aide training course (Staff B) before administering medication to residents.

The findings are:

1. Review of Staff A's, medication aide (MA), personnel record revealed:
-Staff A was hired 05/30/23.
-There was no documentation Staff A had passed the state medication administration exam.
-There was a certificate dated 06/09/23 for completion of the 15-hour medication aide training.
-There was documentation Staff A completed the medication clinical skills checklist on 06/09/23.

Review of residents' June 2023-September 2023 electronic medication administration records (eMAR) revealed:

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D 156	Continued From page 3 -There was documentation Staff A administered medications on 3 days from 08/09/23-08/31/23. -There was documentation Staff A administered medications on 4 days from 09/01/23-09/07/23. Interview with Staff A on 09/14/23 at 2:50pm revealed she had not yet taken the state medication administration exam. Interview with the Administrator on 09/14/23 at 4:10pm revealed she took Staff A off the medication cart on 09/07/23 when she found out Staff A had attempted but did not pass the state medication administration exam. 2. Review of Staff B's, medication aide (MA), personnel record revealed: -Staff B was hired 08/02/23. -There was no documentation Staff B had completed the 5, 10, or 15-hour medication aide training. -There was documentation Staff B passed the state medication administration exam on 04/01/19. -There was documentation Staff B completed the medication clinical skills checklist on 08/07/23. Review of residents' August 2023-September 2023 eMARs revealed: -There was documentation Staff B administered medications on 4 days from 08/07/23-08/24/23. -There was documentation Staff B administered medications on 4 days from 09/01/23-09/13/23. Interview with Staff B on 09/15/23 at 2:55pm revealed: -She started administering medications at the facility as soon as she completed the medication clinical skills. -She had not received a 5, 10, or 15-hour	D 156		

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D 156	Continued From page 4 medication aide training class prior to administering medications at the facility. Interview with the Administrator on 09/15/23 at 4:55pm revealed: -The Resident Care Coordinator (RCC) was responsible for ensuring medication aide staff had received the 5, 10, 15-hour medication aide training prior to administering medications. -She saw Staff B hand a certificate of completion to their registered nurse (RN) trainer. -Staff B identified the certificate as the 15-hour medication aide training. -She did not know what had happened to Staff B's certificate of completion. _____ The facility's failure to ensure two staff who worked as medication aides and administered medications to residents completed the medication aide examination within 60 days from hire (Staff A) and completed at least the 5-hour medication aide training course before administering medications (Staff B) resulted in possible medication errors. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/14/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 30, 2023.	D 156		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident	D 164		

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D 164	Continued From page 5 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled medication aides (Staff A and B) had completed training on the care of diabetic residents prior to obtaining fingerstick blood sugars (FSBS) and administering insulin. The findings are: 1. Review of Staff A's, medication aide (MA),	D 164		

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personnel record revealed:
-Staff A was hired on 05/30/23.
-There was no documentation of training on care of diabetic residents.

Review of a resident's June 2023 electronic medication administration record (eMAR) revealed there was documentation Staff A checked a resident's FSBS 3 times and administered insulin 3 times from 06/01/23 through 06/30/23.

Review of resident's July 2023 eMAR revealed there was documentation Staff A checked a resident's FSBS 8 times and administered insulin 8 times from 07/01/23 through 07/31/23.

Review of resident's August 2023 eMAR revealed there was documentation Staff A checked a resident's FSBS 8 times and administered insulin 8 times from 08/01/23 to 08/31/23.

Review of resident's September 2023 eMAR revealed there was documentation Staff A checked a resident's FSBS 2 times and administered insulin 2 times from 09/01/23 to 09/13/23.

Interview with Staff A on 09/14/23 at 2:56pm revealed:
-An online diabetic training class offered by the facility's contracted pharmacy had been made available to her in July 2023.
-She started the online diabetic training course in July 2023.
-She had only completed 25% of the diabetic training course.

Interview with the Administrator on 09/15/23 at 4:55pm revealed:

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-She did not know Staff A did not complete training on the care of diabetic residents prior to checking a FSBS and administering insulin.
-The Resident Care Coordinator (RCC) was responsible for ensuring the MAs received diabetic training prior to checking a FSBS and administering insulin.

2. Review of Staff B's, medication aide (MA), personnel record revealed:
-Staff B was hired on 08/02/23.
-There was no documentation of training on care of diabetic residents.

Review of a resident's August 2023 electronic Medication Administration Record (eMAR) revealed there was documentation Staff B checked a resident's FSBS 1 time and administered insulin 1 time from 08/01/23 to 08/31/23.

Review of resident's September 2023 eMAR revealed there was documentation Staff B checked a resident's FSBS 12 times and administered insulin 8 times from 09/01/23 to 09/13/23.

Interview with Staff B on 09/15/23 at 2:55pm revealed:
-She did not complete training on the care of diabetic residents.
-She did not know she was supposed to complete training on the care of diabetic residents prior to checking FSBSs and administering insulin.
-She had no prior training on FSBS testing and insulin administration.
-She was shown how to perform FSBS testing, read a sliding scale for insulin dosing, and administer insulin by pen by the Resident Care Coordinator (RCC) prior to being allowed to

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D 164	Continued From page 8 check FSBS and administer insulin without assistance. Interview with the Administrator on 09/15/23 at 4:55pm revealed: -She did not know Staff B did not complete training on the care of diabetic residents prior to checking a FSBS and administering insulin. -The Resident Care Coordinator (RCC) was responsible for ensuring the MAs received diabetic training prior to checking a FSBS and administering insulin.	D 164		
D 186	10A NCAC 13F .0604 (a-b-c) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (a) Adult care homes shall staff to the licensed capacity of the home or to the resident census. When a home is staffing to resident census, a daily census log shall be maintained which lists current residents by name, room assignment and date of admission and must be available for review by the Division of Facility Services and the county departments of social services. (b) Homes with capacity or census of 12 or fewer residents shall comply with the following. (1) At all times there shall be an administrator or administrator-in-charge in the home or within 500 feet of the home with a means of two-way telecommunication. (2) When the administrator or administrator-in-charge is not on duty within the home, there shall be at least one staff member on duty on the first and second shifts and at least one staff member on call within the building on third shift. There shall be a call system	D 186		

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connecting the bedroom of the staff member, who may be asleep on the third shift, with each resident's bedroom.
(3) When the administrator or administrator-in-charge is on duty within the home on the first and second shifts and on call within the home on the third shift, another staff member (i.e., co-administrator, administrator-in-charge or aide) shall be in the building or within 500 feet of the home with a means of two-way telecommunication at all times.
(4) The administrator shall prepare a plan of operation for the home (each home in a cluster) specifying the staff involved, their regularly assigned duties and the amount of time estimated to be spent for each duty. There shall be a current plan of operation on file in the home, available for review by the Division of Facility Services and the county department of social services.
(5) At least 12 hours shall be spent daily providing for the personal services, health services, drug management, planned activities, and other direct services needed by the residents. These duties are the primary responsibility of the staff member(s) on duty on the first and second shifts; however, other help, such as administrator-in-charge and activities coordinator may be used to assist in providing these services.
(6) Between the hours of 9 p.m. and 7 a.m. the staff member on duty and the person on call may perform housekeeping and food service duties as long as a staff member can respond immediately to resident calls or the residents are otherwise supervised. The duties shall not hinder care of residents or immediate response to resident calls, disrupt residents' normal lifestyles and sleeping patterns, nor take a staff member out of

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D 186	Continued From page 10 view of where the residents are. (7) There shall be staff available daily to assure housekeeping and food service. (c) A cluster of homes with capacity or census of 12 or fewer residents shall comply with the following staffing: (1) When there is a cluster of up to six licensed homes located adjacently, there shall be at least one administrator or administrator-in-charge who lives within 500 feet of each of the homes with a means of two-way telecommunication at all times and who is directly responsible for assuring that all required duties are carried out in each home; and (2) In each of the homes, at least one staff member shall be on duty on the first and second shifts and at least one staff member shall be on call within the building during the third shift. There shall be a call system connecting the bedroom of the staff member, who may be asleep on the third shift, with each resident's bedroom. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure there was one staff member on duty within the home on all shifts based on daily census for 5 out of 14 sampled days to provide personal care and supervision of the residents. The findings are: Interview with a medication aide (MA) on 09/13/23 at 8:45am revealed:	D 186		

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-The facility census was 10.
-She was responsible for administering medications from 8:00am to 8:00pm at the facility and to residents at a sister facility on the property.

Observations during the initial tour on 09/13/23 from 8:50am to 10:00am revealed:
-There was a personal care aide (PCA) who was present in the facility.
-The PCA provided breakfast to residents as they awakened and came to the dining room.

Interview with one resident on 09/13/23 at 8:55am revealed:
-The facility was under staffed.
-There was usually one PCA in the building.
-The MA for the facility was responsible to also administer medications to residents in a sister facility on the property.
-She felt there were times when there was no staff available in the facility.

Review of the facility midnight census from 07/23/23 to 07/29/23 revealed:
-On 07/23/23, the census was 11 residents.
-On 07/24/23 to 07/29/23, the census was 12 residents.

Review of the facility's July 2023 staffing schedule from 07/23/23 to 07/29/23 revealed:
-The staffing schedule was written to cover four facilities located on property.
-The day shift was scheduled 8:00am to 8:00pm.
-The night shift was scheduled 8:00pm to 8:00am.
-During the day shift on 07/23/23, there was one MA scheduled in the facility for the shift.
-During the night shift on 07/23/23, there was one PCA scheduled in the facility for the shift.
-During the day shift on 07/24/23, there was one

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MA and one PCA scheduled.
-During the night shift on 07/24/23, there was one PCA scheduled in the facility for the shift.
-During the day shift on 07/25/23, there was one MA and two PCAs scheduled.
-During the night shift on 07/25/23, there was one MA and one PCA scheduled.
-During the day shift on 07/26/23, there was one MA and two PCAs scheduled.
-During the night shift on 07/26/23, there was one MA and one PCA scheduled.
-During the day shift on 07/27/23, there was one MA and one PCA scheduled.
-During the night shift on 07/27/23, there was one MA and one PCA scheduled.
-During the day shift on 07/28/23, there was one MA and one PCA scheduled.
-During the night shift on 07/28/23, there was one MA and one PCA scheduled.
-The facility did not provide the schedule for 07/29/23.

Review of personnel time records and staffing agency paid invoices for 07/23/23 to 07/29/23 revealed:
-The time records and staffing agency paid invoices were for all of the staff who worked in all four facilities on the same property.
-On 07/26/23 8:00am to 8:00pm, there were three MAs with hours worked the entire shift.
-On 07/26/23 8:00pm to 8:00am, there was one PCA and two agency staff who worked the entire shift.
-On 07/27/23 8:00pm to 8:00am, there was two PCAs and one agency staff who worked the entire shift.

Review of the facility midnight census from 08/25/23 to 08/31/23 revealed the census was 10 residents.

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D 186	Continued From page 13 Review of the facility's August 2023 staffing schedule from 08/25/23 to 08/31/23 revealed: -The staffing schedule was written to cover four facilities located on property. -The day shift was 8:00am to 8:00pm. -The night shift was 8:00pm to 8:00am. -The day schedule did specify building assignments for the medication aides (MAs). -The day schedule did not specify building assignments for the personal care aides (PCAs). -The night schedule did not specify building assignments. -During the day shift on 08/25/23, there were two MAs and three PCAs scheduled. -During the night shift on 08/25/23, there were two PCAs scheduled. -During the day shift on 08/26/23, there were two MAs and three PCAs scheduled.. -During the night shift on 08/26/23, there were two PCAs scheduled. -During the day shift on 08/27/23, there were three MAs and one PCA scheduled. -During the night shift on 08/27/23, there were two PCAs scheduled. -During the day shift on 08/28/23, there were three MAs and two PCAs scheduled. -During the night shift on 08/28/23, there were two PCAs scheduled plus agency staffing (no details). -During the day shift on 08/29/23, there were two MAs and four PCAs scheduled. -During the night shift on 08/29/23, there were three PCAs scheduled plus agency staffing (no details). -During the day shift on 08/30/23, there were two MAs and four PCAs scheduled. -During the night shift on 08/30/23, there were two PCAs scheduled. -During the day shift on 08/31/23, there were two	D 186		

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	HAL011376	A. BUILDING: _____ B. WING _____	R-C 09/15/2023

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D 186	Continued From page 14 MAs and four PCAs scheduled. -During the night shift on 08/31/23, there were two PCAs scheduled. Review of personnel time records and staffing agency paid invoices for 08/25/23 to 08/31/23 revealed: -The time records and staffing agency paid invoices were for all of the staff who worked in all four facilities on the same property. -On 08/26/23 8:00pm to 8:00am, there were two PCAs and one agency staff who worked the entire shift. -On 08/29/23 8:00pm to 8:00am, there was one PCA the entire shift, one PCA who worked until 12:00am, and one agency staff for the entire shift. -On 08/31/23 8:00am to 8:00pm, there were two MAs and one PCA who worked the entire shift. -On 08/31/23 8:00pm to 8:00am, there were two MAs the entire shift and one agency staff who worked 6:00pm to 8:00am. Interview with the Administrator on 09/14/23 at 2:00pm revealed: -She had been staying on property to provide support to staff from Sundays to Fridays. -She would go home on Friday evenings and then return to campus on Sunday. -She made sure there was always a MA on duty on the weekends. -She made sure there was always at least one staff in each building for all shifts. -She provided 24 hour/7 day a week telephone support to staff for anything they needed. -The staff schedules prior to 09/01/23 were completed by the Resident Care Coordinator (RCC). -Prior to 09/01/23, there was no way to tell which staff had worked in which buildings and no way to tell when agency staff had worked to cover shifts.	D 186		

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D 186	Continued From page 15 -She recently took over scheduling on 09/01/23 so the schedules reflected clearer staff assignments and included agency staffing hours. Interview with a MA on 09/14/23 at 2:50pm revealed: -She routinely worked day shift. -When there were only two MAs on a shift, the MA was responsible to administer medications in two facilities on property. -There was usually at least one PCA assigned to each facility. -The policy was to have at least one staff in each building at all times. -Otherwise, a PCA would swap buildings and stay with the residents to allow an MA to administer medications in another building. -The Administrator frequently used agency staffing to cover shifts. -The agency staff were "really good" about showing up on short notice to cover shifts. Interview with a second MA on 09/14/23 at 3:30pm revealed: -She routinely worked day shift. -She had never experienced having to work where there was not at least one staff in each facility on property. -The Administrator used agency staffing to cover shifts. Interview with a MA on 09/15/23 at 8:15am revealed: -She routinely worked night shift. -The facilities on property were covered with at least one person to provide care to the residents. -The residents may have gotten up at night and thought there were not staff available, because they did not look on the porch. -Staff were frequently on the porch of the facility	D 186		

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D 186	Continued From page 16 at night. -Their management used a lot of agency staffing to cover shifts. _____ The facility failed to ensure there was at least one staff in the facility at all times for 3 shifts during 07/23/23 to 07/29/23 and 4 shifts during 08/25/23 to 08/31/23 to care for residents. This failure was detrimental to the safety of all the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/15/23 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 30, 2023.	D 186		
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 interviews and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 4 sampled residents (Resident #1) related to notifying the prescriber of incorrect, missed, and refused doses of a insulin and blood sugars greater than 400 as ordered. The findings are:	D 273		

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D 273	Continued From page 17 Review of Resident #1's FL2 dated 02/20/23 revealed diagnoses included Alzheimer's dementia mild stage, diabetes mellitus type 2 uncontrolled, hypertension, cervical degenerative disc disease, history of right hip fracture, history of pelvic fracture, history of knee surgery due to fracture, and osteoarthritis. a. Review of Resident #1's FL2 dated 02/20/23 revealed: -There was an order for Lispro (used to control blood sugar) 100 units/ml inject 7 units before each meal daily at 6:30am, 11:30am, and 4:30pm. -There was an order for fingerstick blood sugar (FSBS) before each meal and inject Lispro 100 units/ml per sliding scale insulin (SSI) FSBS: 0-150=0 unit, 150-199=2 units, 200-249=4 units, 250-299=6 units, 300-350=8 units, 350 or more=0 units and call provider scheduled at 6:30am, 11:30am, and 4:30pm. Review of Resident #1's Endocrinologist's order dated 05/03/23 revealed: -There was an order for Lispro 100 units/ml inject 7 units before breakfast, lunch, and supper. -There was an order for FSBS less than 50, treat low FSBS, delay injection until immediately after the meal, and reduce insulin by 6 units, handwritten beside the order "give patient 1 unit only." -There was an order for FSBS 51-70, immediately eat, take injection just before eating, reduce insulin by 4 units, handwritten beside the order "give patient 3 units only." -There was an order for FSBS 71-150, take prescribed dose of insulin, handwritten beside the order "give 7 units." -There was an order for FSBS before each meal and inject Lispro 100 units/ml per SSI FSBS:	D 273		

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D 273	Continued From page 18 150-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units and call provider if FSBS greater than 400. -There was an order for FSBS before bedtime and inject Lispro 100 units/ml per SSI FSBS: 151-200=None, 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units and call provider if FSBS greater than 400. Review of Resident #1's Endocrinologist's order dated 05/08/23 revealed: -There was an order to change Lispro 100 units/ml inject 7 units before breakfast, 9 units before lunch, and 9 units before supper. -There was an order to continue SSI. Review of Resident #1's Endocrinologist's order dated 06/19/23 revealed: -There was an order for Lispro 100 units/ml inject per insulin scale before meals. -There was an order for Lispro 100 units/ml inject 4 units at lunch plus SSI. -There was an order for Lispro 100 units/ml inject 4 units at supper plus SSI. -Check FSBS four times daily. -Check FSBS anytime resident symptomatic of hypoglycemia. Review of Resident #1's primary care physician (PCP) orders dated 08/18/23 revealed: -There was an order for Lispro 100 units/1ml inject 4 units before lunch and supper. -There was an order to check FSBS before each meal and inject Lispro 100 units/ml inject 15 minutes before meals per SSI: FSBS less than 50=1 unit, 51-70=3 units, 71-150=7 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, if greater than 400 call MD.	D 273		

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D 273	Continued From page 19 Review of Resident #1's July 2023 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Lispro 100 unit/1ml inject 15 minutes before meals per SSI: FSBS less than 50=1 unit, 51-70=3 units, 71-150=7 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, if greater than 400 call MD scheduled at 7:30am, 11:30am, and 4:30pm. -There was an entry for Lispro 100 unit/1ml inject 4 units before lunch and supper scheduled at 11:30am and 4:30pm. -There was an entry for Lispro 100 unit/1ml check FSBS at bedtime and inject per SSI: FSBS 151-200=0 units, 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units scheduled at 8:00pm. -On 07/07/23 at 11:30am, the FSBS was 274, Lispro 100 units/1ml 10 units SSI was documented as administered, when 6 units SSI was ordered. -On 07/10/23 at 7:30am, the FSBS was 349, Lispro 100 units/1ml 4 units SSI was documented as administered, when 8 units SSI was ordered. -On 07/10/23 at 4:30pm, there was no documentation of FSBS, Lispro 100 unit/1ml was administered, and the reason it was not administered. -On 07/13/23 at 8:00pm, the FSBS was 385, Lispro 100 units/1ml 6 units SSI was documented as administered, when 8 units of SSI was ordered. -On 07/24/23 at 4:30pm, the FSBS was 367, Lispro 100 units/1ml 8 units SSI was documented as administered, when 10 units of SSI was ordered. -On 07/25/23 at 11:30am, there was no documentation of FSBS, Lispro 100 unit/1ml was administered, and the reason it was not	D 273		

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administered.
-On 07/25/23 at 4:30pm, there was no documentation of FSBS, Lispro 100 unit/1ml was administered, and the reason it was not administered.
-On 07/29/23 at 4:30pm, the FSBS was 270, Lispro 100 units/1ml 10 units SSI was documented as administered, when 6 units SSI was ordered.
-On 07/31/23 at 11:30am, the FSBS was 178, Lispro 100 units/1ml 6 units SSI was documented as administered, when 2 units SSI was ordered.
-On 07/31/23 at 4:30pm, the FSBS was 198, Lispro 100 units/1ml 6 units SSI was documented as administered, when 2 units SSI was ordered.

Review of Resident #1's August 2023 eMAR revealed:
-There was an entry for Lispro 100 unit/1ml inject 15 minutes before meals per SSI: FSBS less than 50=1 unit, 51-70=3 units, 71-150=7 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, if greater than 400 call MD scheduled at 7:30am, 11:30am, and 4:30pm.
-There was an entry for Lispro 100 unit/1ml inject 4 units before lunch and supper scheduled at 11:30am and 4:30pm.
-There was an entry for Lispro 100 unit/1ml check FSBS at bedtime and inject per SSI FSBS: 151-200=0 units, 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units scheduled at 8:00pm.
-On 08/01/23 at 11:30am, the FSBS was 169, Lispro 100 units/1ml 6 units SSI was documented as administered, when 2 units SSI was ordered.
-On 08/01/23 at 4:30pm, the FSBS was 202, Lispro 100 units/1ml 8 units SSI was documented as administered, when 4 units SSI was ordered.
-On 08/02/23 at 11:30am, the FSBS was 237,

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D 273	Continued From page 21 Lispro 100 units/1ml 8 units SSI was documented as administered, when 4 units SSI was ordered. -On 08/02/23 at 8:00pm, there was no documentation of FSBS, Lispro 100 unit/1ml was administered, and the reason it was not administered. -On 08/07/23 at 4:30pm, the FSBS was 198, Lispro 100 units/1ml 6 units SSI was documented as administered, when 2 units SSI was ordered. -On 08/22/23 at 8:00pm, there was no documentation of FSBS, Lispro 100 unit/1ml was administered, and the reason it was not administered. -On 08/23/23 at 11:30am, there was no documentation of FSBS and Lispro 100 unit/1ml was administered, the documented reason it was not administered was "resident refused." Review of Resident #1's September 2023 eMAR from 09/01/23 to 09/13/23 revealed: -There was an entry for Lispro 100 unit/1ml inject 15 minutes before meals per SSI: FSBS less than 50=1 unit, 51-70=3 units, 71-150=7 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, if greater than 400 call MD scheduled at 7:30am, 11:30am, and 4:30pm. -There was an entry for Lispro 100 unit/1ml inject 4 units before lunch and supper scheduled at 11:30am and 4:30pm. -There was an entry for Lispro 100 unit/1ml check FSBS at bedtime and inject per SSI FSBS: 151-200=0 units, 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units scheduled at 8:00pm. -On 09/02/23 at 4:30pm, the FSBS was 400, Lispro 100 units/1ml 14 units SSI was documented as administered, when 10 units SSI was ordered. -On 09/04/23 at 11:30am, the FSBS was 245,	D 273		

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D 273	Continued From page 22 Lispro 100 units/1ml 8 units SSI was documented as administered, when 4 units SSI was ordered. -On 09/04/23 at 4:30pm, the FSBS was 368, Lispro 100 units/1ml 14 units SSI was documented as administered, when 10 units SSI was ordered. -On 09/06/23 at 11:30am, the FSBS was 233, Lispro 100 units/1ml 8 units SSI was documented as administered, when 4 units SSI was ordered. -On 09/07/23 at 11:30am, the FSBS was 355, Lispro 100 units/1ml 14 units SSI was documented as administered, when 10 units SSI was ordered. -On 09/07/23 at 4:30pm, the FSBS was 358, Lispro 100 units/1ml 14 units SSI was documented as administered, when 10 units SSI was ordered. -On 09/08/23 at 11:30am, the FSBS was 388, Lispro 100 units/1ml 14 units SSI was documented as administered, when 10 units SSI was ordered. -On 09/12/23 at 11:30am, the FSBS was 306, Lispro 100 units/1ml 12 units SSI was documented as administered, when 8 units SSI was ordered. -On 09/12/23 at 4:30pm, the FSBS was 165, Lispro 100 units/1ml 6 units SSI was documented as administered, when 2 units SSI was ordered. Interview with Resident #1 on 09/13/23 at 8:55am revealed: -She was supposed to receive her insulin one half hour before she ate. -She had not yet received her insulin that morning. -On 08/22/23 and 08/23/23, she did not receive her pre-meal lunch insulin until 2:00pm. -Her blood sugars were so "high." -She had to go to the hospital "last week" because her FSBS was 555.	D 273		

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D 273	Continued From page 23 -She had recently been hospitalized at least 3 times due to high blood sugar levels. Interview with a MA on 09/14/23 at 2:50pm revealed: -According to the documentation on Resident #1's eMAR, she administered 6 units of Lispro insulin instead of 8 units of Lispro insulin on 07/13/23 at 8:00pm for a FSBS 385. -She probably had been interrupted during medication pass and had misread 6 units from the eMAR. -She did not know what happened with the missed FSBS's and missed insulin administrations for Resident #1. -She was trained to offer a medication to a resident 3 times when the resident refused to take a medication. -After the third refusal, she was trained to document the refusal on the eMAR. Interview with a second MA on 09/14/23 at 3:30pm revealed: -She did not know why Resident #1 insulin was not administered on several occurrences during July 2023 and August 2023. -If a resident refused to take a medication, she would try at least 3 times to get the resident to take the medication. -If the resident still refused to take the medication, she would document resident refused in the eMAR. Telephone interview with the Clinical Director at Resident #1's Endocrinology office on 09/15/23 at 1:00pm revealed: -They had not received any communication from the facility since April 2023 concerning Resident #1's missed, incorrect, and refused doses of insulin.	D 273		

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-Missed doses of insulin would cause Resident #1 to experience really high blood sugars.
-Resident #1 receiving incorrect insulin doses could cause the resident to also experience really high blood sugars and low blood sugars.
-High blood sugars had negative effects on the kidneys, eyesight, and mental state.
-Low blood sugars could cause the resident to go into a diabetic coma (a life-threatening disorder that causes unconsciousness).

Interview with the Administrator on 09/15/23 at 4:55pm revealed:
-She expected staff to notify Resident #1's physician for instructions on how to manage even 1 missed dose of insulin.
-The Resident Care Coordinator (RCC) was responsible for monitoring medication variance reports daily for missed doses of medications.
-The MAs were trained to tell the RCC immediately about missed medications.
-The RCC was primarily responsible for notifying the physician about missed doses of insulin, incorrect doses of insulin, and refused medications.
-The MAs were also trained to report issues with missed medications and refused medications to physicians.

b. Review of Resident #1's Endocrinologist's order dated 05/03/23 revealed:
-There was an order for fingerstick blood sugar (FSBS) before each meal and inject Lispro 100 units/ml per SSI FSBS: 150-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units and call provider if FSBS greater than 400.
-There was an order for FSBS before bedtime and inject Lispro 100 units/ml per SSI FSBS: 151-200=None, 201-250=2 units, 251-300=4

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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 25 units, 301-350=6 units, 351-400=8 units and call provider if FSBS greater than 400. Review of Resident #1's Endocrinologist's order dated 05/08/23 revealed there was an order to continue SSI. Review of Resident #1's Endocrinologist's order dated 06/19/23 revealed: -There was an order for Lispro 100 units/ml inject per insulin scale before meals. -Check FSBS four times daily. -Check FSBS anytime resident symptomatic of hypoglycemia. Review of Resident #1's primary care physician (PCP) orders dated 08/18/23 revealed: -There was an order to check FSBS before each meal and inject Lispro 100 units/ml inject 15 minutes before meals per SSI: FSBS less than 50=1 unit, 51-70=3 units, 71-150=7 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, if greater than 400 call MD. Review Resident #1's July 2023 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Lispro 100 unit/1ml inject 15 minutes before meals per SSI: FSBS less than 50=1 unit, 51-70=3 units, 71-150=7 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, if greater than 400 call MD scheduled at 7:30am, 11:30am, and 4:30pm. -There was an entry for Lispro 100 unit/1ml check FSBS at bedtime and inject per SSI FSBS: 151-200=0 units, 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units scheduled at 8:00pm.	D 273		

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D 273	Continued From page 26 -On 07/12/23 at 11:30am, the FSBS was 403, and there was no documentation the physician was notified. -On 07/14/23 at 11:30am, the FSBS was 431, and there was no documentation the physician was notified. -On 07/27/23 at 4:30pm, the FSBS was 450, and there was no documentation the physician was notified. Review of Resident #1's August 2023 eMAR revealed: -There was an entry for Lispro 100 unit/1ml inject 15 minutes before meals per SSI: FSBS less than 50=1 unit, 51-70=3 units, 71-150=7 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, if greater than 400 call MD scheduled at 7:30am, 11:30am, and 4:30pm. -There was an entry for Lispro 100 unit/1ml check FSBS at bedtime and inject per SSI FSBS: 151-200=0 units, 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units scheduled at 8:00pm. -On 08/22/23 at 11:30am, the FSBS was 421, and there was no documentation the physician was notified. -On 08/23/23 at 4:30pm, the FSBS was 436, and there was no documentation the physician was notified. -On 08/23/23 at 8:00pm, the FSBS was 415, and there was no documentation the physician was notified. Review of Resident #1's September 2023 eMAR 09/01/23 to 09/13/23 revealed: -There was an entry for Lispro 100 unit/1ml inject 15 minutes before meals per SSI: FSBS less than 50=1 unit, 51-70=3 units, 71-150=7 units, 151-200=2 units, 201-250=4 units, 251-300=6	D 273		

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D 273	Continued From page 27	D 273		

units, 301-350=8 units, 351-400=10 units, if greater than 400 call MD scheduled at 7:30am, 11:30am, and 4:30pm.
-There was an entry for Lispro 100 unit/1ml check FSBS at bedtime and inject per SSI FSBS: 151-200=0 units, 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units scheduled at 8:00pm.
-On 09/08/23 at 4:30pm, the FSBS was 407, and there was no documentation the physician was notified.
-On 09/08/23 at 8:00pm, the FSBS was 415, and there was no documentation the physician was notified.
-On 09/09/23 at 4:30pm, the FSBS was 412, and there was no documentation the physician was notified.

Interview with Resident #1 on 09/13/23 at 8:55am revealed:
-Her blood sugars were so "high."
-She had to go to the hospital "last week" because her FSBS was high.
-She had recently been hospitalized at least 3 times due to high blood sugar levels.
-She did not think her Endocrinologist was aware of the frequency of her FSBS being greater than 400.
-The facility staff were supposed to notify the Endocrinologist anytime her FSBS was greater than 400, however the staff tell her most of the time they cannot reach the Endocrinologist to report issues to him.

Interview with a medication aide (MA) on 09/14/23 at 2:50pm revealed:
-She was told by the Resident Care Coordinator (RCC) to report FSBS greater than 400 to the physician for Resident #1.
-If the resident used their primary care provider

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(PCP) then she used a software application on her phone to leave messages for the facility PCP.
-Resident #1 did not use the facility PCP, so any FSBS greater than 400 would need to be called to Resident #1's physician.

Interview with a second MA on 09/14/23 at 3:30pm revealed:
-She was trained to contact Resident #1's physician when the residents FSBS was greater than 400.
-Once the physician was notified, she would expect the physician to call back to advise what needed to be done next for the resident when the FSBS was over 400.
-If Resident #1's FSBS was over 400 and she was unable to reach a physician, she would call 911 and send Resident #1 out for evaluation at the local hospital.

Telephone interview with Resident #1's primary care physician (PCP) on 09/15/23 at 9:32am revealed:
-High blood sugars could put Resident #1 in the hospital.
-High blood sugars made Resident #1 confused, could increase her risk of infections, and caused damage to the resident's kidneys.
-Resident #1 had not been coming in for her appointments, so she had not been aware of the high blood sugars.
-She had recently received a call from the facility to ask if they could have an order to discontinue Resident #1's blood sugar checks which was totally inappropriate.

Telephone interview with the Clinical Director at Resident #1's Endocrinology office on 09/15/23 at 1:00pm revealed:
-The Endocrinologist wanted to be notified of all

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D 273	Continued From page 29 FSBS that were greater than 400. -The Endocrinologist expected to know when Resident #1's blood sugars were greater than 400, so adjustments could be made to her medications. -There had not been any communication from facility staff since April 2023 about the frequency Resident #1 had experienced blood sugars greater than 400. Interview with the Administrator on 09/15/23 at 4:55pm revealed: -If Resident #1's FSBS was greater than 400, she expected staff to contact Resident #1's Endocrinologist immediately. -If staff could not reach the Endocrinologist, then she expected staff to contact Resident #1's PCP to report the high blood sugar. _____ The facility's failure to notify Resident #1's physicians regarding missed, incorrect, and refused doses of insulin increased Resident #1's risk of high blood sugars which had negative effects on the resident's kidneys, eyesight, and mental state and low blood sugars which could cause the resident to go into a diabetic coma. This failure was detrimental to the health, safety, and welfare of Resident #1 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/15/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 30, 2023.	D 273		

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D 344	Continued From page 30	D 344		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 4 sampled residents (#1) related to sliding scale insulin orders that were not clarified. The findings are: 1. Review of Resident #1's FL2 dated 02/20/23 revealed diagnoses included Alzheimer's dementia mild stage, diabetes mellitus type 2 uncontrolled, hypertension, cervical degenerative disc disease, history of right hip fracture, history of pelvic fracture, history of knee surgery due to fracture, and osteoarthritis. a. Review of Resident #1's Endocrinologist's order dated 05/03/23 revealed: -There was an order for Lispro (used to manage	D 344		

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blood glucose) 100 units/ml inject 7 units before breakfast, lunch, and supper.
-There was an order for fingerstick blood sugar (FSBS) less than 50, treat low FSBS, delay injection until immediately after the meal, and reduce insulin by 6 units, handwritten beside the order "give patient 1 unit only."
-There was an order for FSBS 51-70, immediately eat, take injection just before eating, reduce insulin by 4 units, handwritten beside the order "give patient 3 units only."
-There was an order for FSBS 71-150, take prescribed dose of insulin, handwritten beside the order "give 7 units."
-There was an order for FSBS before each meal and inject Lispro 100 units/ml per sliding scale insulin (SSI): 150-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units and call provider if FSBS greater than 400.
-There was an order for FSBS before bedtime and inject Lispro 100 units/ml per SSI: 151-200=None, 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units and call provider if FSBS greater than 400.

Review of Resident #1's Endocrinologist's order dated 05/08/23 revealed:
-There was an order to change Lispro 100 units/ml inject 7 units before breakfast, 9 units before lunch, and 9 units before supper.
-There was an order to continue SSI.

Review of Resident #1's Endocrinologist's note dated 06/14/23 revealed:
-A facility medication aide (MA) called their office stating Resident #1 was having issues with low blood glucose values.
-They took Resident #1 to the hospital as a result of the low blood glucose values.
-The MA was advised when Resident #1 was

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discharged to call our office and move follow-up appointment sooner so that they could assess and see if Resident #1 needed adjustments to her medications.

Review of Resident #1's Endocrinologist's order dated 06/19/23 revealed:
-There was an order for Lispro 100 units/ml inject per SSI before meals.
-There was an order for Lispro 100 units/ml inject 4 units at lunch plus SSI.
-There was an order for Lispro 100 units/ml inject 4 units at supper plus SSI.
-Check FSBS four times daily.
-Check FSBS anytime resident symptomatic of hypoglycemia.

Review of Resident #1's primary care physician (PCP) orders dated 08/18/23 revealed:
-There was an order for Lispro 100 units/ml inject 4 units before lunch and supper.
-There was an order to check FSBS before each meal and inject Lispro 100 units/ml inject 15 minutes before meals per SSI, FSBS less than 50=1 unit, 51-70=3 units, 71-150=7 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, if greater than 400 call MD.

Review of Resident #1's July 2023 electronic Medication Administration Record (eMAR) revealed:
-There was an entry dated 06/20/23 for Lispro 100 unit/1ml inject 15 minutes before meals per SSI : FSBS less than 50=1 unit, 51-70=3 units, 71-150=7 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, if greater than 400 call MD scheduled at 7:30am, 11:30am, and 4:30pm.
-On 07/28/23 at 7:30am, the FSBS was 134, 7

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units of Lispro 100 units/1ml were documented as administered when no SSI was ordered.
-On 07/29/23 at 11:30am, the FSBS was 95, 11 units of Lispro 100 units/1ml were documented as administered when no SSI was ordered.
-On 07/30/23 at 4:30pm, the FSBS was 119, 4 units of Lispro 100 units/1ml were documented as administered when no SSI was ordered.

Review of Resident #1's August 2023 eMAR revealed:
-There was an entry for Lispro 100 unit/1ml inject 15 minutes before meals per SSI: FSBS less than 50=1 unit, 51-70=3 units, 71-150=7 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, if greater than 400 call MD scheduled at 7:30am, 11:30am, and 4:30pm.
-On 08/04/23 at 7:30am, the FSBS was 88, 7 units of Lispro 100 units/1ml were documented as administered when no SSI was ordered.
-On 08/04/23 at 11:30am, the FSBS was 102, 7 units of Lispro 100 units/1ml were documented as administered when no SSI was ordered.

Review of Resident #1's September 2023 eMAR from 09/01/23 to 09/13/23 revealed:
-There was an entry for Lispro 100 unit/1ml inject 15 minutes before meals per SSI: FSBS less than 50=1 unit, 51-70=3 units, 71-150=7 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, if greater than 400 call MD scheduled at 7:30am, 11:30am, and 4:30pm.
-On 09/10/23 at 7:30am, the FSBS was 100, 7 units of Lispro 100 units/1ml were documented as administered when no SSI was ordered.
-On 09/13/23 at 7:30am, the FSBS was 105, 7 units of Lispro 100 units/1ml were documented as administered when no SSI was ordered.

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D 344	Continued From page 34 Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/14/23 at 9:25am revealed: -A pharmacist with their pharmacy had transcribed Resident #1's insulin orders dated 05/03/23 into the eMAR system. -The sliding scale did not look correct based on the 05/03/23 order that was available in their system. -The way he read the order if the blood sugar was less than 50, the premeal insulin dosage should be reduced by 6 units and no SSI would be needed. -If the blood sugar was 51-70, the premeal insulin dosage should be reduced by 4 units and no SSI would be needed. -If the blood sugar was 71-150, the full amount of prescribed premeal insulin should be administered and no SSI would be needed. -The order was "poorly written." -He would correct the order in the eMAR system. Interview with a medication aide (MA) on 09/14/23 at 8:45am revealed: -Resident #1's FSBS was 98 at 7:30am on 09/14/23. -She administered 7 units of sliding scale Lispro insulin to Resident #1. -She followed the sliding scale in the eMAR system. -She did not question the order as it was in the eMAR system. Telephone interview with the Clinical Director at Resident #1's Endocrinology office on 09/15/23 at 1:00pm revealed: -When additional insulin was administered to Resident #1 when the blood sugar was less than 150, it could cause Resident #1's blood sugar to	D 344		

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D 344	Continued From page 35 drop very low which could lead to a diabetic coma (a life-threatening disorder causing unconsciousness). _____ The facility failed to clarify unclear sliding scale insulin orders resulting in Resident #1 receiving insulin when the resident did not require sliding scale insulin, increasing the resident's risk of very low blood sugar which could lead to diabetic coma. This was detrimental to the health, safety, and welfare and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/20/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 30, 2023.	D 344		
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, interviews, and record reviews, the facility failed to administer medications as prescribed for 4 of 4 sampled	D 358		

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residents (#1, #2, #3, and #4) related to medications used to treat diabetes and pain (#1), chronic obstructive pulmonary disease (COPD) (#4), a possible kidney stone (#3), and very dry skin and prevention of fungal infections (#2).

The findings are:

1. Review of Resident #1's FL2 dated 02/20/23 revealed diagnoses included Alzheimer's dementia mild stage, diabetes mellitus type 2 uncontrolled, hypertension, cervical degenerative disc disease, history of right hip fracture, history of pelvic fracture, history of knee surgery due to fracture, and osteoarthritis.

a. Review of Resident #1's FL2 dated 02/20/23 revealed:
-There was an order for Lispro (used to control blood sugars) 100 units/ml inject 7 units before each meal daily at 6:30am, 11:30am, and 4:30pm.
-There was an order for fingerstick blood sugar (FSBS) before each meal and inject Lispro 100 units/ml sliding scale insulin (SSI), FSBS: 0-150=0 unit, 150-199=2 units, 200-249=4 units, 250-299=6 units, 300-350=8 units, 350 or more=0 units and call provider scheduled at 6:30am, 11:30am, and 4:30pm.

Review of Resident #1's Endocrinologist's order dated 05/03/23 revealed:
-There was an order for Lispro 100 units/ml inject 7 units before breakfast, lunch, and supper.
-There was an order for FSBS less than 50, treat low FSBS, delay injection until immediately after the meal, and reduce insulin by 6 units, and handwritten beside the order "give patient 1 unit only."
-There was an order for FSBS 51-70, immediately

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eat, take injection just before eating, reduce insulin by 4 units, and handwritten beside the order "give patient 3 units only."
-There was an order for FSBS 71-150, take prescribed dose of insulin, and handwritten beside the order "give 7 units."
-There was an order for FSBS before each meal and inject Lispro 100 units/ml SSI, FSBS: 150-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units and call provider if FSBS greater than 400.
-There was an order for FSBS before bedtime and inject Lispro 100 units/ml SSI, FSBS: 151-200=None, 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units and call provider if FSBS greater than 400.

Review of Resident #1's Endocrinologist's order dated 05/08/23 revealed:
-There was an order to change Lispro 100 units/ml inject 7 units before breakfast, 9 units before lunch, and 9 units before supper.
-There was an order to continue SSI.

Review of Resident #1's Endocrinologist's order dated 06/19/23 revealed:
-There was an order for Lispro 100 units/ml inject per SSI before meals.
-There was an order for Lispro 100 units/ml inject 4 units at lunch plus SSI.
-There was an order for Lispro 100 units/ml inject 4 units at supper plus SSI.
-Check FSBS four times daily.
-Check FSBS anytime resident symptomatic of hypoglycemia.

Review of Resident #1's primary care physician (PCP) orders dated 08/18/23 revealed:
-There was an order for Lispro 100 units/ml inject 4 units before lunch and supper.

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D 358	Continued From page 38 -There was an order to check FSBS before each meal and inject Lispro 100 units/ml inject 15 minutes before meals per SSI, FSBS less than 50=1 unit, 51-70=3 units, 71-150=7 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, if greater than 400 call MD. Review of Resident #4's discharge summary dated 08/20/23 revealed she presented to the hospital with a blood sugar of 444. Review of Resident #1's July 2023 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Lispro 100 unit/1ml inject 15 minutes before meals per SSI, FSBS less than 50=1 unit, 51-70=3 units, 71-150=7 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, if greater than 400 call MD scheduled at 7:30am, 11:30am, and 4:30pm. -There was an entry for Lispro 100 unit/1ml inject 4 units before lunch and supper scheduled at 11:30am and 4:30pm. -There was an entry for Lispro 100 unit/1ml check FSBS at bedtime and inject per SSI, FSBS 151-200=0 units, 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units scheduled at 8:00pm. -On 07/07/23 at 11:30am, the FSBS was 274, Lispro 100 units/1ml 10 units SSI was documented as administered, when 6 units SSI was ordered. -On 07/10/23 at 7:30am, the FSBS was 349, Lispro 100 units/1ml 4 units SSI was documented as administered, when 8 units SSI was ordered. -On 07/10/23 at 4:30pm, there was no documentation of FSBS, Lispro 100 unit/1ml was administered, and reason it was not administered.	D 358		

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D 358	Continued From page 39 -On 07/13/23 at 8:00pm, the FSBS was 385, Lispro 100 units/1ml 6 units SSI was documented as administered, when 8 units of SSI was ordered. -On 07/24/23 at 4:30pm, the FSBS was 367, Lispro 100 units/1ml 8 units SSI was documented as administered, when 10 units of SSI was ordered. -On 07/25/23 at 11:30am, there was no documentation of FSBS, Lispro 100 unit/1ml was administered, and reason it was not administered. -On 07/25/23 at 4:30pm, there was no documentation of FSBS, Lispro 100 unit/1ml was administered, and reason it was not administered. -On 07/29/23 at 4:30pm, the FSBS was 270, Lispro 100 units/1ml 10 units SSI was documented as administered, when 6 units SSI was ordered. -On 07/31/23 at 11:30am, the FSBS was 178, Lispro 100 units/1ml 6 units SSI was documented as administered, when 2 units SSI was ordered. -On 07/31/23 at 4:30pm, the FSBS was 198, Lispro 100 units/1ml 6 units SSI was documented as administered, when 2 units SSI was ordered. Review of Resident #1's August 2023 eMAR revealed: -There was an entry for Lispro 100 unit/1ml inject 15 minutes before meals per SSI, FSBS less than 50=1 unit, 51-70=3 units, 71-150=7 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, if greater than 400 call MD scheduled at 7:30am, 11:30am, and 4:30pm. -There was an entry for Lispro 100 unit/1ml inject 4 units before lunch and supper scheduled at 11:30am and 4:30pm. -There was an entry for Lispro 100 unit/1ml check FSBS at bedtime and inject per SSI, FSBS 151-200=0 units, 201-250=2 units, 251-300=4	D 358		

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units, 301-350=6 units, 351-400=8 units scheduled at 8:00pm.
-On 08/01/23 at 11:30am, the FSBS was 169, Lispro 100 units/1ml 6 units SSI was documented as administered, when 2 units SSI was ordered.
-On 08/01/23 at 4:30pm, the FSBS was 202, Lispro 100 units/1ml 8 units SSI was documented as administered, when 4 units SSI was ordered.
-On 08/02/23 at 11:30am, the FSBS was 237, Lispro 100 units/1ml 8 units SSI was documented as administered, when 4 units SSI was ordered.
-On 08/02/23 at 8:00pm, there was no documentation of FSBS, Lispro 100 unit/1ml was administered, and reason it was not administered..
-On 08/07/23 at 4:30pm, the FSBS was 198, Lispro 100 units/1ml 6 units SSI was documented as administered, when 2 units SSI was ordered.
-On 08/22/23 at 8:00pm, there was no documentation of FSBS, Lispro 100 unit/1ml was administered, and reason it was not administered.
-On 08/23/23 at 11:30am, there was no documentation of FSBS, Lispro 100 unit/1ml was administered, and the documented reason it was not administered was "resident refused."

Review of Resident #1's September 2023 eMAR from 09/01/23 to 09/13/23 revealed:
-There was an entry for Lispro 100 unit/1ml inject 15 minutes before meals per SSI, FSBS less than 50=1 unit, 51-70=3 units, 71-150=7 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, if greater than 400 call MD scheduled at 7:30am, 11:30am, and 4:30pm.
-There was an entry for Lispro 100 unit/1ml inject 4 units before lunch and supper scheduled at 11:30am and 4:30pm.
-There was an entry for Lispro 100 unit/1ml check FSBS at bedtime and inject per SSI, FSBS

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D 358	Continued From page 41 151-200=0 units, 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units scheduled at 8:00pm. -On 09/02/23 at 4:30pm, the FSBS was 400, Lispro 100 units/1ml 14 units SSI was documented as administered, when 10 units SSI was ordered. -On 09/04/23 at 11:30am, the FSBS was 245, Lispro 100 units/1ml 8 units SSI was documented as administered, when 4 units SSI was ordered. -On 09/04/23 at 4:30pm, the FSBS was 368, Lispro 100 units/1ml 14 units SSI was documented as administered, when 10 units SSI was ordered. -On 09/06/23 at 11:30am, the FSBS was 233, Lispro 100 units/1ml 8 units SSI was documented as administered, when 4 units SSI was ordered. -On 09/07/23 at 11:30am, the FSBS was 355, Lispro 100 units/1ml 14 units SSI was documented as administered, when 10 units SSI was ordered. -On 09/07/23 at 4:30pm, the FSBS was 358, Lispro 100 units/1ml 14 units SSI was documented as administered, when 10 units SSI was ordered. -On 09/08/23 at 11:30am, the FSBS was 388, Lispro 100 units/1ml 14 units SSI was documented as administered, when 10 units SSI was ordered. -On 09/12/23 at 11:30am, the FSBS was 306, Lispro 100 units/1ml 12 units SSI was documented as administered, when 8 units SSI was ordered. -On 09/12/23 at 4:30pm, the FSBS was 165, Lispro 100 units/1ml 6 units SSI documented as administered, when 2 units SSI was ordered. Interview with Resident #1 on 09/13/23 at 8:55am revealed: -She was supposed to receive her insulin one half	D 358		

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hour before she ate.
-She had not yet received her insulin that morning.
-If she did not get her insulin, then she did not eat breakfast.
-On 08/22/23 and 08/23/23, she did not receive her pre-meal lunch insulin until 2:00pm.
-Her blood sugars were so "high."
-She had to go to the hospital "last week" because her FSBS was 555.
-She did not remember if she had missed insulin doses on 08/22/23 or 08/23/23.
-She had recently been hospitalized at least 3 times due to high blood sugar levels.

Observation of a MA on 09/14/23 at 11:55am revealed:
-Resident #1's FSBS was 232.
-The MA injected 8 units of Lispro into Resident #1's left upper arm.

Interview with a MA on 09/14/23 at 2:50pm revealed:
-According to the documentation on Resident #1's eMAR, she administered 6 units of Lispro insulin instead of 8 units of Lispro insulin on 07/13/23 at 8:00pm for a FSBS 385.
-She had completed 25% of the online diabetic training course.
-She did not know what happened with the missed FSBS's and missed insulin administrations for Resident #1.

Interview with a second MA on 09/14/23 at 3:30pm revealed:
-She did not know why Resident #1's insulin was not administered on several occurrences during July 2023 and August 2023.
-If the time for administration was one hour after the scheduled administration time, the MAs were

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trained to contact the physician for orders on what to do and if the insulin should be administered late.

Telephone interview with the Clinical Director at Resident #1's Endocrinology office on 09/15/23 at 1:00pm revealed:
-The resident's insulin should be administered exactly as ordered.
-Missed doses of insulin would cause Resident #1 to experience high blood sugars.
-Resident #1 receiving incorrect insulin doses could cause the resident to also experience high blood sugars and low blood sugars.
-High blood sugars had negative effects on the kidneys, eyesight, and mental state.
-Low blood sugars could cause the resident to go into a diabetic coma (a life-threatening disorder that causes unconsciousness).

Interview with the Administrator on 09/15/23 at 4:55pm revealed:
-She expected staff to administer Resident #1's insulin as ordered.
-The Resident Care Coordinator (RCC) was responsible for monitoring medication variance reports daily for missed doses of medications.
-The RCC was responsible for monitoring situations where the MAs were reporting very high and very low blood sugars to them.

b. Review of Resident #1's primary care physician's (PCP) order dated 05/02/23 revealed tramadol (used to treat pain) 50mg 1 tablet two times a day as needed for severe pain.

Interview with Resident #1 on 09/15/23 at 2:05pm revealed:
-She was hurting in her lower and upper back.
-She knew she had an order for tramadol for

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pain.
-She had not asked for any today to help with her pain because the last time she asked the staff for one they told her they did not have any available.
-She had needed something to manage her back pain since she went to the hospital on 08/17/23 for treatment for a very high blood sugar.

Review of Resident #1's August 2023 to September 2023 electronic Medication Administration Records (eMARs) revealed:
-There were entries for tramadol 50mg 1 tablet twice daily as needed for severe pain.
-There were no documented administrations of tramadol for 08/01/23 to 09/01/23.

Observation of Resident #1's medications on hand on 09/13/23 at 4:12pm revealed there was no tramadol available.

Review of Resident #1's tramadol controlled substance control sheet (CSCS) dated 05/05/23 to 06/17/23 revealed:
-There were 30 tramadol 50 mg tablets received on 05/04/23.
-The last of the tramadol was documented as administered on 06/17/23.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/14/23 at 9:25am revealed:
-They had an active order for tramadol 50mg 1 tablet twice a day as needed for severe pain dated 05/03/23.
-They dispensed 30 tablets of tramadol 50mg on 05/03/23.
-They had not dispensed any additional tramadol for Resident #1.

Interview with a medication aide (MA) on

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D 358	Continued From page 45 09/15/23 at 2:20pm revealed: -She knew Resident #1 experienced chronic pain in her back. -She took Resident #1 to an appointment back in May 2023 to see her PCP and they discussed the residents chronic pain issues. -Resident #1 told the PCP the tramadol did not help with her pain. -She did not think the tramadol order was still active. Interview with the Administrator on 09/15/23 at 4:55pm revealed: -The Resident Care Coordinator (RCC) was responsible for weekly medication cart audits. -Since the RCC position was currently vacant, the Assistant Administrator from a sister facility had come in and conducted weekly medication cart audits. -No one had told her Resident #1 was in pain and did not have tramadol available for administration. 2. Review of Resident #4's current FL2 dated 05/29/23 revealed diagnoses included chronic obstructive pulmonary disease (COPD), gastroesophageal reflux disease, diabetes mellitus and hypertension. a. Review of Resident #4's current FL2 dated 05/29/23 revealed -There was an order for morphine 20mg/1ml (used to treat pain and COPD) take 0.25ml every 6 hours as needed. -There was an order for morphine 20mg/1ml take 0.25ml every 4 hours as needed. Review of hospital discharge summary dated 08/25/23 revealed: -Resident #4 was admitted to the hospital on 08/20/23 at 7:25am.	D 358		

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D 358	Continued From page 46 -Resident #4's discharge diagnoses were medication overdose, anxiety, and COPD. -The resident reported she received a "double dose" of a medication the day prior (08/19/23) to presentation (to the emergency room) but could not remember what medication. -She developed tremulousness (affected with trembling or tremors). -She was admitted to the hospital for observation and did not have a reoccurrence of the symptoms. Review of Resident #4's July 2023 electronic Medication Administration Record (eMAR) revealed: -There was a entry for morphine 20mg/1ml take 0.25ml every 4 hours as needed for pain and COPD. -The morphine was documented as administered 28 times from 07/01/23 to 07/31/23. Review of Resident #4's August 2023 eMAR revealed: -There was an entry for morphine 20mg/1ml take 0.25ml every 2 hours as needed for pain and COPD. -There was an entry for morphine 20mg/1ml take 0.25ml every 4 hours as needed for pain and COPD. -The morphine was documented as administered every 2 hours for 31 times from 08/10/23 through 08/19/23. -The morphine was documented as administered every 4 hours for 13 times from 08/01/23 to 08/09/23. Observation of Resident #4's medications on hand in the medication cart on 09/13/23 at 2:15pm revealed there were 33 syringes of morphine available.	D 358		

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D 358	Continued From page 47 Review of Resident #4's controlled substance count sheet (CSCS) revealed: -The CSCS was dated 08/30/23. -There were 33 syringes of morphine 20mg/1ml solution remaining. Telephone interview with the facility's contracted pharmacy representative on 09/14/23 at 2:35pm revealed: -The morphine 20mg/1ml solution in syringes was first dispensed on 04/17/23. -There were 12 syringes of morphine dispensed on 04/17/23. -There were 30 syringes of morphine dispensed on 04/24/23. -There were 30 syringes of morphine dispensed on 05/09/23. -There were 30 syringes of morphine dispensed on 06/13/23. -There were 30 syringes of morphine dispensed on 08/03/23. -There were 60 syringes of morphine dispensed on 08/09/23. Telephone interview with Resident #4 on 09/12/23 at 9:00pm revealed the facility staff gave her too much medication but she could not remember which medication it was. Telephone interview with Resident #4's Nurse Practitioner (NP) on 09/14/23 at 3:25pm revealed: -Resident #4 was admitted to the hospital on 09/20/23. -It was possible Resident #4 could have been administered a double dose of morphine by facility staff. -Emergency Medical Services (EMS) who responded to take Resident #4 to the hospital did not use Narcan (used to treat overdose) on	D 358		

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Resident #4.
-The resident had a current order for morphine 20mg/1ml take 0.25ml every 2 hours as needed for pain and COPD.

Interview with the Administrator on 09/13/23 at 4:05pm revealed:
-She was unaware Resident #4's medications were not being administered as ordered.
-The RCC was expected to ensure all medications were administered as ordered.

Refer to the interview with the Assistant Administrator from a sister facility on 09/13/23 at 3:15pm.

b. Review of Resident #4's current FL2 dated 05/29/23 revealed:
-There was an order for albuterol (used to treat COPD) 0.083% inhale one vial twice daily.
-There was no current order to self-administer the albuterol.

Review of Resident #4's July 2023 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for albuterol 0.083% 1 vial via nebulizer twice a day scheduled at 8:00am and 8:00pm.
-The albuterol was documented as administered twice daily as ordered.

Review of Resident #4's August 2023 eMAR revealed:
-There was an entry for albuterol 0.083% 1 vial via nebulizer twice a day scheduled at 8:00am and 8:00pm.
-The albuterol was documented as administered twice daily from 08/01/23 to 08/19/23 with exceptions.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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-On 08/07/23, the initials of the documenting medication aide (MA) were circled at 8:00am and 8:00pm with a note albuterol was "self-admin."
-On 08/17/23, the initials of the documenting MA were circled at 8:00pm with a note albuterol was "self-admin."
-All documentation ended on 08/19/23 as Resident #4 was in the hospital.

Observation of Resident #4's medications on hand in the medication cart on 09/13/23 at 2:15pm revealed there was no albuterol available.

Observation of Resident #4's room on 09/15/23 at 2:30pm revealed:
-There was an unopened box of albuterol 0.083% under the bed with a dispense date of 04/27/23.
-There was another box of albuterol 0.083% under the bed with a dispense date of 11/10/22 with 23 of 30 vials remaining.

Telephone interview with Resident #4 on 09/12/23 at 8:45pm revealed:
-She no longer lived at the facility.
-She had not been receiving her nebulizer treatments when she lived at the facility.
-The medication staff just stopped giving them to her.

Telephone interview with facility's contracted pharmacy representative on 09/14/23 at 2:35pm revealed they had not dispensed any albuterol for Resident #4 since they became the facility's contracted pharmacy.

Telephone interview with Resident #4's Nurse Practitioner (NP) on 09/14/23 at 3:25pm revealed:
-Resident #4 was ordered albuterol nebulizer treatments for COPD.
-The staff at the facility were not consistently

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assisting with Resident #4's nebulizer treatments.

Interview with the Administrator on 09/13/23 at 4:05pm revealed:
-She was unaware Resident #4's medications were not being administered as ordered.
-The RCC was expected to ensure all medications were administered as ordered.

Interview with the Administrator on 09/15/23 at 4:55pm revealed:
-The Resident Care Coordinator (RCC) was responsible for weekly medication cart audits.
-Since the RCC had stopped working at the facility, the Assistant Administrator from a sister facility had come in and conducted weekly medication cart audits.
-The RCC was responsible for monitoring medication variance reports daily for missed doses of medications.

Refer to the interview with the Assistant Administrator from a sister facility on 09/13/23 at 3:15pm.

c. Review of Resident #4's current FL2 dated 05/29/23 revealed:
-There was an order for budesonide (used to treat COPD) inhale one vial twice daily.
-There was no current order to self-administer the budesonide.

Review of Resident #4's July 2023 electronic Medication Administration Record (eMAR) revealed:
-There was an entry of budesonide 0.25mg/2ml suspension inhale 1 vial per nebulizer twice a day scheduled at 8:00am and 8:00pm.
-The budesonide was documented as administered twice daily with an exception on

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07/10/23 with an explanation the medication was "self-admin."
-On 07/19/23 at 8:00pm, the budesonide was documented as not administered and there was no documentation as to why the medication was not administered.
-On 07/25/23 at 8:00am, the budesonide was documented as not administered and there was no documentation as to why the medication was not administered.

Review of Resident #4's August 2023 eMAR revealed:
-There was an entry for budesonide 0.25mg/0.2ml inhale one vial per nebulizer twice daily scheduled at 8:00am and 8:00pm.
-The budesonide was documented as administered twice daily with exceptions.
-On 08/07/23, the medication aide's (MA) initials were circled at 8:00am and 8:00pm with the explanation budesonide was "self-admin."
-On 08/17/23, the MA initials were circled at 8:00pm with the explanation budesonide was "self-admin."
-All documentation ended on 08/19/23 as Resident #4 was in the hospital.

Observation of Resident #4's medication on hand in the medication cart on 09/13/23 at 2:15pm revealed there was no budesonide available.

Observation of Resident #4's room on 09/15/23 at 2:30pm revealed:
-There was an open box of budesonide under the bed Resident #4's bed.
-The box of 60 vials of budesonide was dispensed on 04/27/23.
-There were 29 out of 60 vials of budesonide remaining in the box.

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Telephone interview with Resident #4 on 09/12/23 at 8:45pm revealed:
-She no longer lived at the facility.
-She had not been receiving her nebulizer treatments when she lived at the facility.
-The medication staff just stopped giving them to her.

Telephone interview with the facility's contracted pharmacy representative on 09/14/23 at 2:35pm revealed they had not dispensed any budesonide for Resident #4.

Telephone interview with Resident #4's Nurse Practitioner (NP) on 09/14/23 at 3:25pm revealed the staff at the facility were not consistently assisting with Resident #4's nebulizer treatments.

Interview with the Administrator on 09/13/23 at 4:05pm revealed:
-She was unaware Resident #4's medications were not being administered as ordered.
-The RCC was expected to ensure all medications were administered as ordered.

Interview with the Administrator on 09/15/23 at 4:55pm revealed the RCC was responsible for monitoring medication variance reports daily for missed doses of medications.

Refer to the interview with the Assistant Administrator from a sister facility on 09/13/23 at 3:15pm.

d. Review of Resident #4's current FL2 dated 05/29/23 revealed:.
-There was an order for formoterol (used to treat COPD) inhale one vial 2 times daily via nebulizer twice a day.
-There was no current order to self-administer the

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D 358	Continued From page 53 formoterol. Review of Resident #4's July 2023 electronic Medication Administration Record (eMAR) revealed: -There was an entry for formoterol 20mcg/2ml inhale 1 vial via nebulizer twice a day scheduled at 8:00am and 8:00pm. -The formoterol was documented as administered twice daily with an exception on 07/10/23 with an explanation the medication was "self-admin." Review of Resident #4's August 2023 eMAR revealed: -There was an entry for formoterol 20mcg/2ml inhale 1 vial via nebulizer twice a day scheduled at 8:00am and 8:00pm. -Formoterol was documented as administered twice daily with exceptions. -On 08/07/23 at 8:00am, the fomoterol was documented as not administered with the explanation "self-admin." -On 08/07/23 at 8:00pm, the fomoterol was documented as not administered with the explanation "self-admin." -On 08/08/23 at 8:00pm, the fomoterol was documented as not administered with the explanation "self-admin." -On 08/14/23 at 8:00pm, the fomoterol was documented as not administered with the explanation "resident refused." -On 08/17/23 at 8:00pm, the fomoterol was documented as not administered with the explanation "resident refused." -All documentation ended on 08/19/23 as Resident #4 was sent to the hospital. Observation of Resident #4's medications on hand in the medication cart on 09/13/23 at	D 358		

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D 358	Continued From page 54 2:15pm revealed no formoterol was available. Observation of Resident #4's room on 09/15/23 at 2:30pm revealed there was no formoterol available. Telephone interview with Resident #4 on 09/12/23 at 8:45pm revealed: -She no longer lived at the facility. -She had not been receiving her nebulizer treatments when she lived at the facility. -The medication staff just stopped giving them to her. Telephone interview with facility's contracted pharmacy representative on 09/14/23 at 2:35pm revealed they had not dispensed any fomoterol for Resident #4 since they became the facility's contracted pharmacy. Telephone interview with Resident #4's Nurse Practitioner (NP) on 09/14/23 at 3:25pm revealed the staff at the facility were not consistently assisting with Resident #4's nebulizer treatments. Interview with the Administrator on 09/15/23 at 4:55pm revealed the RCC was responsible for monitoring medication variance reports daily for missed doses of medications. Refer to the interview with the Assistant Administrator from a sister facility on 09/13/23 at 3:15pm. e. Review of Resident #4's current FL2 dated 05/29/23 revealed: -There was an order for Yupelri (used to treat COPD) 175mg/3ml inhale one vial daily. -There was no current order to self-administer the Yupelri.	D 358		

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D 358	Continued From page 55 Review of Resident #4's July 2023 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Yupelri 175mg/3ml inhale 1 vial via nebulizer once daily scheduled at 8:00am. - Yupelri was documented as administered daily with an exception on 07/07/23 with an explanation the medication was "self-admin." Review of Resident #4's August 2023 eMAR revealed: -There was an entry for Yupelri 175mg/3ml inhale 1 vial via nebulizer once daily scheduled at 8:00am. -The Yupelri was documented as administered daily with an exception on 07/07/23 with an explanation the medication was "self-admin." -All documentation ended on 08/19/23 as Resident #4 was sent to the hospital. Observation of the medication on hand in the medication cart on 09/13/23 at 2:15pm revealed there was no Yupelri available. Observation of Resident #4's room on 09/15/23 at 2:30pm revealed: -There was an open box of Yupelri under the resident's bed. -The box was dispensed on 11/10/22. -There were 13 vials of Yulperi remained out of 30 vials. Telephone interview with Resident #4 on 09/12/23 at 8:45pm revealed: -She no longer lived at the facility. -She had not been receiving her nebulizer treatments when she lived at the facility. -The medication staff just stopped giving them to	D 358		

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D 358	Continued From page 56 her. Telephone interview with facility's contracted pharmacy representative on 09/14/23 at 2:35pm revealed they had not dispensed any nebulizer treatments for Resident #4 since they became the facility's contracted pharmacy. Telephone interview with Resident #4's Nurse Practitioner (NP) on 09/14/23 at 3:25pm revealed the staff at the facility were not consistently assisting with Resident #4's nebulizer treatments. Interview with the Administrator on 09/15/23 at 4:55pm revealed the RCC was responsible for monitoring medication variance reports daily for missed doses of medications. Refer to the interview with the Assistant Administrator from a sister facility on 09/13/23 at 3:15pm. 3. Review of Resident #3's current FL2 dated 01/23/23 revealed diagnoses included Wernicke's disease (a degenerative brain disorder caused by the lack of thiamine (vitamin b1) and features problems requiring new information or establishing new memories and retreiving previous memories), hyperlipidemia, history of gastric bypass, short term memory loss. Review of Resident #3's physician's orders dated 06/19/23 revealed tamsulosin 0.4mg capsule (used to treat kidney stones) take one capsule by mouth at bedtime for 28 days. Review of Resident #3's June 2023 electronic medication administration record (eMAR) revealed:	D 358		

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D 358	Continued From page 57 -There was no entry for tamsulosin 0.4mg capsule. -There was no documentation tamsulosin 0.4 mg capsule was administered from 06/20/23 through 06/30/23. Review of Resident #3's July 2023 eMAR revealed: -There was no entry for tamsulosin 0.4mg capsule. -There was no documentation tamsulosin 0.4mg capsule was administered from 07/01/23 through 07/17/23. Interview with a representative with the contracted pharmacy on 09/13/23 at 4:24pm revealed: -Tamsulosin was dispensed on 06/20/23 for 28 days. -There were 28 tabs dispensed. Interview with a medication aide (MA) on 09/14/23 at 3:45pm revealed: -The nurse practitioner (NP) notified the resident care coordinator (RCC) and the Administrator when he wrote an order. -The RCC faxed all orders to the pharmacy. -The pharmacy was responsible for entering the orders in the eMAR. -When a medication was delivered to the facility, the RCC or Administrator were responsible to approve the medication. -She knew how to approve medications but had never approved a medication before and would need permission from the RCC and the Administrator before she could approve a medication. -After the medications were approved, the order would be visible on the eMAR as available to administer.	D 358		

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D 358	Continued From page 58 Interview with the Assistant Administrator on 09/13/23 at 3:45pm revealed: -The RCC was responsible for ensuring NP orders were followed. -The MAs were trained on how to process new medications orders. -The NP faxed all orders to the pharmacy. -The RCC faxed all NP orders to pharmacy a second time. -She and the RCC were responsible for ensuring medications were delivered to the facility by checking medication carts. -The RCC was responsible for making sure the medications were approved and entered on the eMARS and administered according to the NP orders. -She was responsible for making sure the RCC carried out her responsibilities related to medication order processing accordingly. Interview with Resident #3's NP on 09/14/23 at 3:15pm revealed: -The facility did not notify him that Resident #3's tamsulosin was not administered as ordered. -He was not aware the tamsulosin was never entered on the eMAR or administered. -He ordered Resident #3 tamsulosin for kidney stones and hematuria (blood in urine) to help the kidney stone pass faster and more easily. -Resident #3 could experience increased pain, more blood in the urine, and prolonged pain from not passing the kidney stone since she was not administered the tamsulosin as ordered. Interview with the Administrator on 09/15/23 at 4:55pm revealed: -The Resident Care Coordinator (RCC) was responsible for weekly medication cart audits. -Since the RCC had stopped working at the	D 358		

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facility, the Assistant Administrator from a sister facility had come in and conducted weekly medication cart audits.
-The RCC was responsible for monitoring medication variance reports daily for missed doses of medications.

Interview with the Administrator on 09/15/23 at 5:15pm revealed:
-The NP faxed his medication orders written by him to the pharmacy himself.
-The pharmacy entered the orders into the eMAR system.
-The NP gave all orders to the RCC.
-If the RCC wasn't there, the NP would have given all orders to the Administrator.
-The RCC would checkfor accuracy on the eMAR.
-The RCC was responsible to inform the pharmacy if the medications were on the eMAR.

Refer to the interview with the Assistant Administrator from a sister facility on 09/13/23 at 3:15pm.

4. Review of Resident #2's current FL2 dated 10/18/22 revealed diagnoses included diabetes mellitus type 2.

a. Review of Resident #2's physician's orders dated 07/10/23 revealed there was a medication order for urea 10% cream (used to treat dry skin) apply topically twice daily as needed for dry skin.

Review of Resident #2's July 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for urea 10% cream apply topically twice daily as needed for dry skin, may self-administer.

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D 358	Continued From page 60 -There was no documentation urea 10% cream was administered from 07/01/23 through 07/31/23. Review of Resident #2's August 2023 eMAR revealed: -There was an entry for urea 10% cream apply topically twice daily as needed for dry skin, may self-administer. -There was no documentation urea 10% cream was administered from 08/01/23 through 08/31/23. Review of Resident #2's 09/01/23 through 09/13/23 eMAR revealed: -There was an entry for urea 10% cream apply topically twice daily as needed for dry skin, may self-administer. -There was no documentation urea 10% cream was administered from 09/01/23 through 09/13/23. Observation of Resident #2's medications on hand on 09/14/23 at 9:34am revealed there was no urea 10% cream available for administration. Interview with Resident #2 on 09/13/23 at 12:05pm revealed: -She had diabetes mellitus type 2 and had dry skin especially on her feet. - She sometimes developed cracks in the skin on her feet from the dryness. -She used urea 10% cream to help the dryness of her skin. -Her tube of urea 10% cream was empty, and she told a medication aide (MA) about 3 weeks ago that the urea cream needed to be refilled. -She still had not received the urea cream since she told the MA she needed a refill 3 weeks ago. -Her feet were "really dry", and the left foot was	D 358		

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cracking.
-It always took 2 to 3 weeks to get a medication refilled when she ran out of any medications.

Observation of Resident #2's feet on 09/14/23 at 8:36am revealed:
-Both feet were dry and scaly.
-There was approximately a 1-inch sized crack and callused area around the outer perimeter of the left big toe.
-The left and right heels were dry and scaly.

Interview with a MA on 09/14/23 at 9:17am revealed:
-Resident #2's urea cream was last requested to be dispensed by the pharmacy on 07/05/23.
-The MAs were responsible to ask Resident #2 if she used the urea cream and document the self-administration on the eMAR.
-She did not ask Resident #2 if she had used the urea cream on her skin.
-She did not know if Resident #2 had urea cream available to self-administer or when Resident #2 last used the urea cream.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/14/23 at 10:52am revealed:
-Resident #2's urea cream was last dispensed on 07/05/23 in the quantity of 85 grams.
-Since Resident #2's urea cream was administered as needed, it was unknown how long the cream should last.
-The urea cream was not on a cycle fill and must be requested as a refill by the facility.
-The facility had not requested a refill for Resident #2's urea cream since it was last dispensed on 07/05/23.

Telephone interview with Resident #2's primary

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care provider (PCP) on 09/14/23 at 3:15pm revealed:
-He ordered urea 10% cream for Resident #2 to treat dry skin.
-The facility did not notify him that Resident #2 was unable to self-administer the urea cream due to the medication being unavailable.
-Resident #2 could experience increased dry skin and itching due to not being administered the urea cream.

Interview with the Administrator on 09/15/23 at 3:40pm revealed:
-The MAs were responsible for requesting medication refills for residents.
-She did not know Resident #2's urea cream was unavailable for administration.
-The MAs were responsible for medication cart audits weekly to check for medications on low supply and request medication refills if the medications were not already reordered.
-The eMAR system allowed the MAs to see when a medication was last requested to be refilled.
-The former RCC kept up with the medication cart audit logs and it was unknown where the logs were since the RCC left about a week ago.
-She expected the MAs to request medication refills for medications in low supply so that the medications were available to administer as ordered.

Refer to the interview with the Assistant Administrator from a sister facility on 09/13/23 at 3:15pm.

b. Review of Resident #2's physician's orders dated 07/10/23 revealed a medication order for ketoconazole 2% cream (used to treat a fungal infection) apply twice daily, may self-administer.

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D 358	Continued From page 63 Interview with Resident #2 on 09/13/23 at 12:05pm revealed: -Her tube of ketoconazole 2% cream was empty, and she told a medication aide (MA) about 3 weeks ago that the cream needed to be refilled. -She still had not received the ketoconazole cream since she told the MA she needed a refill 3 weeks ago. -Her feet were "really dry", and the left foot was cracking. -She used the ketoconazole cream on her feet. -It always took 2 to 3 weeks to get a medication refilled when she ran out of any medications. Review of Resident #2's July 2023 electronic medication administration record (eMAR) revealed: -There was an entry for ketoconazole 2% cream apply topically twice daily at 8:00am and 8:00pm, may self-administer. -There was documentation ketoconazole cream was administered at 8:00am on 07/01/23, 07/02/23, 07/04/23-07/10/23, 07/12/23-07/14/23, 07/16/23, 07/18/23-07/19/23, 07/21/23-07/27/23, and 07/29/23-07/31/23. -There was no documentation ketoconazole cream was administered at 8:00am on 07/17/23 or 07/20/23. -Ketoconazole cream was documented as not administered on 07/03/23 at 8:00am with the reason documented as self-administered. -Ketoconazole cream was documented as not administered at 8:00am on 07/11/23, 07/15/23, and 07/28/23 with the reason documented as resident refused. -There was documentation ketoconazole cream was administered at 8:00pm on 07/01/23-07/09/23, 07/12/23-07/14/023, and 07/16/23-07/31/23. -Ketoconazole cream was documented as not	D 358		

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administered at 8:00pm on 07/10/23 with the reason documented as self-administered.
-Ketoconazole cream was documented as not administered at 8:00pm on 07/11/23 and 07/15/23 with the reason documented as resident refused.

Review of Resident #2's August 2023 eMAR revealed:
-There was an entry for ketoconazole 2% cream apply topically twice a day at 8:00am and 8:00pm, may self-administer.
-There was documentation ketoconazole cream was administered at 8:00am on 08/01/23, 08/02/23, 08/04/23-08/08/23, 08/10/23, 08/12/23-08/21/23, 08/23/23-08/25/23, 08/27/23, 08/28/23, and 08/30/23.
-Ketoconazole cream was documented as not administered at 8:00am on 08/03/23, 08/09/23, 08/11/23, 08/22/23, and 08/29/23 with the reason documented as resident refused.
-Ketoconazole cream was documented as not administered at 8:00am on 08/31/23 with the reason documented as self-administered.
-There was no documentation ketoconazole cream was administered at 8:00am on 08/26/23.
-There was documentation ketoconazole cream was administered at 8:00pm on 08/01/23-08/02/23, 08/04/23-08/06/23, 08/08/23-08/16/23, 08/18/23-08/25/23, 08/27/23, and 08/29/23.
-Ketoconazole cream was documented as not administered at 8:00pm on 08/07/23 and 08/30/23 with the reason documented as self-administered.
-Ketoconazole cream was documented as not administered at 8:00pm on 08/17/23 with the reason documented as out of the facility.
-Ketoconazole cream was documented as not administered at 8:00pm on 08/03/23, 08/26/23, 08/28/23, and 08/31/23 with the reason

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D 358	Continued From page 65 documented as resident refused. Review of Resident #2's 09/01/23 through 09/13/23 eMAR revealed: -There was an entry for ketoconazole 2% cream apply topically twice a day at 8:00am and 8:00pm, may self-administer. -There was documentation ketoconazole cream was administered at 8:00am on 09/02/23-09/04/23, 09/07/23-09/08/23, 09/11/23, and 09/13/23. -Ketoconazole cream was documented as not administered at 8:00am on 09/01/23, 09/05/23, and 09/06/23 with the reason documented as resident refused. -Ketoconazole cream was documented as not administered at 8:00am on 09/09/23 and 09/10/23 with the reason documented as self-administered. -Ketoconazole cream was documented as not administered at 8:00am on 09/12/23 with the reason documented as "didn't see it". -There was documentation ketoconazole cream was administered at 8:00pm on 09/02/23, 09/03/23, 09/08/23, and 09/11/23. -Ketoconazole cream was documented as not administered at 8:00pm on 09/01/23 and 09/12/23 with the reason documented as resident refused. -Ketoconazole cream was documented as not administered at 8:00pm on 09/04/23, 09/05/23, 09/07/23, 09/09/23, and 09/10/23 with the reason documented as self-administered. -There was no documentation ketoconazole cream was administered at 8:00pm on 09/06/23. Observation of Resident #2's medications on hand on 09/14/23 at 9:34am revealed there was no ketoconazole 2% cream available for administration.	D 358		

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D 358	Continued From page 66 Interview with a MA on 09/14/23 at 9:17am revealed: -Resident #2's ketoconazole 2% cream was last requested to be dispensed by the pharmacy on 06/23/23. -Resident #2's ketoconazole 2% cream was scheduled to be administered twice daily. -The MAs were responsible to ask Resident #2 if she used the ketoconazole cream and document the self-administration on the eMAR. -She accidentally documented Resident #2's ketoconazole cream was administered on 09/13/23 at 8:00am when she documented the other scheduled medications as administered. -She did not know if Resident #2 had ketoconazole cream available to self-administer or when Resident #2 last used the ketoconazole cream. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/14/23 at 10:52am revealed: -Resident #2's ketoconazole cream was last dispensed on 06/23/23. -The ketoconazole cream was scheduled to be administered twice daily and the quantity of days the cream would last would depend on how much of the cream was administered to the affected areas. -The ketoconazole cream was not on a cycle fill and must be requested as a refill by the facility. -The facility had not requested a refill for Resident #2's ketoconazole cream since it was last dispensed on 06/23/23. Telephone interview with Resident #2's primary care provider (PCP) on 09/14/23 at 3:15pm revealed: -He ordered ketoconazole 2% cream for Resident	D 358		

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#2 to treat a fungal infection.
-The facility did not notify him that Resident #2 was unable to self-administer the ketoconazole cream due to the medication being unavailable.
-Resident #2 could experience an increased fungal infection causing red, itchy, or scaly rash due to not being administered the ketoconazole cream.

Interview with the Administrator on 09/15/23 at 3:40pm revealed:
-The MAs were responsible for requesting medication refills for residents.
-She did not know Resident #2's ketoconazole cream was unavailable for administration.
-The MAs were responsible for medication cart audits weekly to check for medications on low supply and request medication refills if the medications were not already reordered.
-The eMAR system allowed the MAs to see when a medication was last requested to be refilled.
-The former RCC kept up with the medication cart audit logs and it was unknown where the logs were since the RCC left about a week ago.
-She expected the MAs to request medication refills for medications in low supply so that the medications were available to administer as ordered.

Refer to the interview with the Assistant Administrator from a sister facility on 09/13/23 at 3:15pm.

_____

Interview with the Assistant Administrator from a sister facility on 09/13/23 at 3:15pm revealed:
-She was currently working at the facility part time to help since the former Resident Care Coordinator (RCC) left about a week ago.
-The MAs were responsible for requesting medication refills from the pharmacy when a

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D 358	Continued From page 68 medication was in low supply. -The MAs were responsible for medication cart audits weekly on Wednesdays and she did not know when the last cart audit was completed. -The former RCC kept up with the medication cart audit logs and it was unknown where the logs were located. _____ The facility failed to administer medications as ordered resulting in Resident #4 being hospitalized 5 days for possible morphine overdose and Resident #1 experiencing very low and high blood sugars and requiring hospitalization. This failure resulted in serious physical harm and constitutes a Type A1 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/13/23 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 15, 2023.	D 358		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure there was an accurate accounting for the receipt,	D 392		

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administration, and disposition of controlled medications for 2 of 2 sampled residents (#2 and #4) related to medications to treat pain (#2 and #4).

The findings are:

1. Review of Resident #4 ' s current FL2 dated 05/29/23 revealed:
-There were diagnoses of chronic obstructive pulmonary disease (COPD), gastroesophageal reflux disease, diabetes mellitus, and hypertension.
-There was an order for morphine (a schedule II controlled medication used to treat pain) 20mg/1ml take 0.25ml every 6 hours as needed for pain.
-There was an order for morphine 20mg/1ml take 0.25ml every 4 hours as needed for pain.

Review Resident #4's July 2023 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for morphine 20mg/1ml take 0.25ml every 4 hours as needed for pain/breathlessness related to end stage COPD.
-The morphine was documented as administered 28 times between 07/01/23 to 07/31/23.

Review of Resident #4's August 2023 eMAR from 08/01/23 to 08/19/23 revealed:
-There was an entry for morphine 20mg/1ml take 0.25ml every 2 hours as needed for pain/breathlessness related to end stage COPD.
-There was an entry for morphine 20mg/1ml take 0.25ml every 4 hours as needed as needed for pain/breathlessness related to end stage COPD.
-The morphine every 2 hours was documented as administered 31 times from 08/10/23 through 08/19/23.

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D 392	Continued From page 70 -The morphine every 4 hours was documented as administered 13 times from 08/01/23 to 08/09/23. Telephone interview with facility's contracted pharmacy representative on 09/14/23 at 2:35pm revealed: -Resident #4's morphine was first dispensed on 04/17/23. -There were 12 syringes of morphine dispensed on 04/17/23. -There were 30 syringes of morphine dispensed on 04/24/23. -There were 30 syringes of morphine dispensed on 05/09/23. -There were 30 syringes of morphine dispensed on 06/13/23. -There were 30 syringes of morphine dispensed on 08/03/23. -There were 60 syringes of morphine dispensed on 08/09/23. Review of Resident #4's morphine Controlled Substance Control Sheets (CSCS) revealed: -From 04/18/23 through 04/24/23, 12 doses were received, and 12 doses were documented as administered. -From 04/24/23 through 05/09/23, 30 doses were received, and 30 doses were documented as administered. -From 05/10/23 through 07/06/23, 30 doses were received, and 30 doses were documented as administered. -From 07/17/23 through 08/03/23 2:00am, 30 doses were received, and 30 doses were documented as administered. -There was no CSCS for the 30 doses received from the pharmacy on 08/03/23. -There was no CSCS for the 60 doses received from the pharmacy on 08/09/23.	D 392		

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Review of Resident #4's record revealed:
-There were 30 doses of the 30 morphine syringes dispensed on 08/03/23 and documented as administered from 08/04/23 1:51pm through 08/15/23 6:14am.
-There were 12 doses of the 60 morphine syringes dispensed on 08/09/23 and documented as administered from 08/15/23 8:44am through 08/19/23 1:51am.
-There was no documentation for the other 48 syringes of 60 syringes of morphine dispensed on 08/09/23.

Review of Resident #4's handwritten morphine Controlled Substance Control Sheet (CSCS) revealed:
-The CSCS was dated 08/30/23 with 33 morphine syringes remaining.
-There was no pharmacy label on the CSCS.

Observation of Resident #4's medication on hand on the medication cart on 09/13/23 at 2:15pm revealed:
-There was 33 syringes remaining of a quanity of 60 syringes of morphine with a dispense date of 08/09/23.
-There should have been 48 syringes of morphine remaining.
-There was no documentation for the missing 15 syringes of morphine.

Refer to the interview with the Assistant Administrator from a sister facility on 09/14/23 at 4:11pm.

Refer to the interview with the Administrator on 09/15/23 at 11:35am.

2. Review of Resident #2's current FL2 dated 10/18/22 revealed diagnoses chronic pain and

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D 392	Continued From page 72 peripheral neuropathy. Review of Resident #2's physician's orders dated 07/10/23 revealed an order for hydrocodone (a medication used to treat pain) 10mg/325mg take 1 tablet three times a day as needed for pain. Review of Resident #2's July 2023 electronic medication administration record (eMAR) revealed: -There was an entry for hydrocodone 10mg/325mg take 1 tablet three times daily as needed for pain. -There was documentation hydrocodone was administered 32 instances out of 93 opportunities. Review of Resident #2's August 2023 eMAR revealed: -There was an entry for hydrocodone 10mg/325mg take 1 tablet three times daily as needed for pain. -There was documentation hydrocodone was administered 24 instances out of 93 opportunities. Review of Resident #2's 09/01/23 through 09/13/23 eMAR revealed: -There was an entry for hydrocodone 10mg/325mg take 1 tablet three times daily as needed for pain. -There was documentation hydrocodone was administered 10 instances out of 39 opportunities. Observation of Resident #2's medications on hand on 09/14/23 at 9:34am revealed there was a bubble pack of hydrocodone 10mg/325mg dispensed on 07/24/23 in the quantity of 30 tablets with 6 tablets remaining. Review of Resident #2's inventory history for hydrocodone 10mg/325mg tablets revealed:	D 392		

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D 392	Continued From page 73 -The inventory history sheet did not contain a label for Resident #2's hydrocodone 10mg/325mg tablets. -There was handwritten documentation in the space where the label would be placed with Resident #2's name, prescription number, medication and dosage, instructions on how to administer the hydrocodone, and there was no dispense date or quantity of tablets documented. -The first line of the inventory sheet was dated 08/30/23 at 8:30am with a balance of 20 tablets remaining. Interview with a medication aide (MA) on 09/14/23 at 9:40am revealed: -She did not know what happened to Resident #2's original inventory history sheet for hydrocodone. -The notebook containing all the inventory history sheets for all the resident's-controlled substances went missing recently. -The Assistant Administrator from a sister facility searched for the notebook containing the inventory sheets for controlled substances on 08/30/23 and could not find it so the Assistant Administrator hand wrote new inventory history sheets. Refer to the interview with the Assistant Administrator from a sister facility on 09/14/23 at 4:11pm. Refer to the interview with the Administrator on 09/15/23 at 11:35am. _____ Interview with the Assistant Administrator from a sister facility on 09/14/23 at 4:11pm revealed: -She worked at the facility on 08/30/23 when the control substance notebook with the inventory	D 392		

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history sheets was missing.
-The control substance notebook went missing on 08/29/23.
-She and the Administrator reviewed the camera footage, and the notebook went missing when the video footage went blank.
-The former Resident Care Coordinator (RCC) instructed the MA on duty on 08/29/23 to create new inventory history sheets for all the residents with controlled substances.
-The former RCC did not call the facility's contracted pharmacy to inventory the cart to see if any of the controlled substances were missing.
-The MA on duty on 08/29/23 hand wrote the inventory history sheets for the controlled substances and documented the balance on the sheets by counting the tablets remaining in each bubble pack.
-The MA called the facility's contracted pharmacy to ask the amounts dispensed of the controlled medications for residents but did not compare the amount dispensed with what was administered or the remaining balances.
-She did not know if there were any controlled medications missing from the medication cart.

Interview with the Administrator on 09/15/23 at 11:35am revealed:
-She reviewed the video camera footage on 08/29/23 around 8:00pm after the former RCC reported the controlled medication inventory history notebook was missing.
-The timeframe on 08/29/23 at 12:46pm showed the controlled medication inventory history notebook lying on top of the medication cart.
-The next timeframe appeared at 12:51pm and the controlled medication inventory history notebook was not lying on top of the medication cart where it was previously located.
-The Assistant Administrator worked on 08/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011376	A. BUILDING: _____ B. WING _____	R-C 09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL ASSISTED LIVING # 1	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

(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 392	Continued From page 75 and called the pharmacy and audited the medication cart and reported to her that all the controlled substances were accounted for. -She did not contact the facility's contracted pharmacy for an medication cart inventory or a local law enforcement agency for suspected narcotics diversion because she thought all the resident's-controlled substances were accounted for. _____ The facility failed to maintain controlled substance records to enable accurate reconciliation of Resident #4's controlled substances which resulted in the diversion of 15 syringes of morphine 20mg. This failure was detrimental to the health, safety, and welfare of Resident #4 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/15/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 30, 2023.	D 392		
D 399	10A NCAC 13F .1008 (h) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (h) The facility shall ensure that all known drug diversions are reported to the pharmacy, local law enforcement agency and Health Care Personnel Registry as required by state law, and that all suspected drug diversions are reported to the pharmacy. There shall be documentation of the contact and action taken.	D 399		

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D 399	Continued From page 76 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to report suspected drug diversion to the faciliy's contracted pharmacy, local law enforcement, and the health care personnel registry (HCPR). The findings are: Interview with the Assistant Administrator from a sister facility on 09/15/23 at 11:00am revealed: -The narcotics log went missing from the facility on 08/29/23. -The Administrator reviewed the camera recording from 08/29/23 for the time in question. -The camera showed the narcotics log lying on the medication cart, then the camera goes black. -When the camera comes back up, the narcotics log had disappeared. -The Resident Care Coordinator (RCC) had the personal care aides (PCAs) to search the facility and look for the narcotics log book on 08/30/23. -The PCAs were unable to find the narcotics log. -She also searched the facility herself on 08/30/23, but was unable to find the narcotics log. a. Interview with the Assistant Administrator from a sister facility on 09/15/23 at 11:00am revealed: -The Administrator did not contact the facility's contracted pharmacy about suspected drug diversion in the facility. -She called the pharmacy on 08/30/23 and told the pharmacy the narcotics log for the facility had been stolen.	D 399		

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D 399	Continued From page 77	D 399		

-She went over some of the narcotic dispense records on 08/30/23 of some of the narcotic medications available on the medication cart.
-She and the pharmacy did not go over all the dispense records of every narcotic stored on the medication cart.
-No one from the pharmacy had been out to the facility to try to reconcile the supply of available narcotic medications to ensure the counts were accurate.

Review of the health care personnel registry (HCPR) initial allegation report dated 08/30/23 revealed:
-The date the facility became aware of the incident was 08/29/23 at 8:00pm.
-Allegation details included possible drug diversion and misappropriation of resident property.

Interview with the Administrator on 09/15/23 at 11:35am revealed:
-The Assistant Administrator worked on 08/30/23 and called the pharmacy and audited the medication cart and reported to her that all the controlled substances were accounted for.
-She did not contact the facility's contracted pharmacy for an medication cart inventory because she thought all the resident's controlled substances were accounted for.

b. Interview with the Assistant Administrator from a sister facility on 09/15/23 at 11:00am revealed:
-The Administrator placed a call to local law enforcement to report suspected drug diversion on 08/30/23.
-The Sheriff's office was closed and was to reopen on 08/31/23 at 8:00am.
-She did not think the Administrator ever called local law enforcement back after the initial

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D 399	Continued From page 78	D 399		

attempt on 08/31/23 to report the missing controlled substances log.

Review of the HCPR inital allegation report dated 08/30/23 revealed:
-The date the facility became aware of the incident was 08/29/23 at 8:00pm.
-Law enforcement had not been notified about the incident as of 08/30/23 at 8:00pm.

Interview with the Administrator on 09/14/23 at 3:50pm revealed:
-She was not aware there were 15 syringes of morphine 20mg missing from the facility medication cart.
-She would call law enforcement, but would continue investigating first.

Interview with the Administrator on 09/15/23 at 11:40am revealed she did not follow through with contacting law enforcement because she thought all the resident's controlled substances were accounted for.

c. Interview with the Assistant Administrator from a sister facility on 09/15/23 at 11:00am revealed:
-The Administrator completed an initial allegation report to the Health Care Personnel Registry concerning the controlled substance log being taken on 08/30/23.
-She did not think the Administrator ever completed the investigation of the incident.

Review of the HCPR inital allegation report dated 08/30/23 revealed:
-The allegation documented on the report included possible drug diversion and misappropriation of resident property.
-The incident date occurred on 08/29/23.
-The date the facility became aware of the

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D 399	Continued From page 79 incident was 08/29/23 at 8:00pm. Interview with the Administrator on 09/15/23 at 11:40am revealed: -She completed the initial HCPR report within 24 hours. -She failed to get the HCPR 5-day report completed and turned into HCPR. -She completed the HCPR 5-day report and sent it to the HCPR today (09/15/23). _____ The facility failed to notify the pharmacy, law enforcement agency, and Health Care Personnel Registry as required with known drug diversion. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/15/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 30, 2023.	D 399		