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D 000	Initial Comments The Adult Care Licensure Section completed a follow-up survey on 10/17/23-10/20/23.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observation, interviews and record reviews, the facility failed to notify the Endocrinologist and the primary care provider (PCP) for 2 of 2 sampled residents (Resident #4 and #3) related to fingerstick blood sugar (FSBS) readings greater than 400 (#4) and for a pharmacist recommendation to discontinue 1 of 2 antidepressant medications (#3). 1. Review of Resident #4's current FL2 dated 9/20/23 revealed diagnoses included diabetes. Review of Resident #4's Endocrinologist orders dated 04/01/22 revealed there was an order for Lantus (a slow acting insulin used to control diabetes) 15 units subcutaneous twice daily as well as sliding scale insulin (SSI) four times daily and with bedtime as follows: FSBS: 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, over 400 give 0 units and call the physician for instructions. Review of Resident #4's August 2023 medication administration record (MAR) revealed: -There was documentation FSBS results over 400 ranged from 403-498.	D 273		

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D 273	Continued From page 1 -There were FSBS over 400 on 08/02/23 at 4:00pm, 08/04/23 at 4:00pm and 8:00pm, 08/06/23 at 12:00pm, 08/07/23 at 8:00pm,08/09/23 at 8:00am, 08/10/23 at 8:00am and 12:00pm, 08/11/23 at 8:00am, 08/14/23 at 8:00am, 08/15/23 at 8:00am, 08/16/23 at 12:00pm, 08/17/23 at 8:00pm, 08/18/23 at 8:00pm, 08/20/23 at 4:00pm, 08/21/23 at 8:00pm, 08/23/23 at 8:00am. -There was no documentation the Endocrinologist was notified. Review of Resident #4's September 2023 MAR revealed: -There was documentation FSBS over 400 ranged from 408- HI (over 500). -There were FSBS over 400 on 09/03/23 at 12:00pm, 09/05/23 at 8:00am, 09/06/23 at 8:00pm, 09/09/23 at 8:00pm, 09/12/23 at 8:00am, 09/13/23 at 8:00am, 09/23/23 at 4:00pm and 8:00pm, 09/30/23 at 4:00pm. -There was no documentation the Endocrinologist was notified. Review of Resident #4's October 2023 MAR revealed: -There was documentation FSBS over 400 ranged from 447-HI (over 500). -There were FSBS over 400 on 10/01/23 at 8:00am, 10/02/23 at 4:00pm, 10/08/23 at 8:00am, 10/09/23 at 8:00pm, 08/14/23 at 8:00pm,10/15/23 at 12:00pm and 10/17/23 at 4:00pm. -There was no documentation the Endocrinologist was notified. Review of Resident #4's nursing notes revealed there was no documentation the Endocrinologist had been notified of Resident #4's blood sugars being over 400.	D 273		

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Interview with Resident #4 on 10/19/23 at 9:25am revealed:
-He agreed the Endocrinologist had spoken with him about the risk of high and low blood sugars but did not remember what they were.
-He was not aware if staff called his Endocrinologist when his blood sugar was high or not.
-He thought staff had taken him to his last Endocrinologist appointment.

Interview with a medication aide (MA) on 10/19/23 at 8:55am revealed:
-She did not recall any dates she tried to call the Endocrinologist but she was sure she had called about Resident #4's blood sugar being over 400 because she did not know how much insulin to give.
-She left a message for an on-call physician and waited for them to call back to ask what to do about Resident #4's blood sugar being over 400 but could not recall when she had called.
-She had no documentation to show she had called an on-call physician or the Endocrinologist for Resident #4.
-An on-call physician had not called back.
-She had not tried to call the Endocrinologist again.
-She did not call every time Resident #4's FSBS was over 400 and did not document every time she had called.

Interview with the Administrator on 10/19/23 at 9:07am revealed:
-The MA was responsible for notifying the physicians while the Resident Care Coordinator (RCC) was away from the facility during August and September.
-She was not aware the MA had not notified the Endocrinologist as ordered when Resident #4's

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blood sugar was over 400.
-She stated the Endocrinologist was hard to get in touch with on weekends as there was no one on call for the physician.

Interview with the RCC on 10/19/23 at 10:20am revealed:
-She had not been at the facility in August 2023 and much of September 2023 and was not aware the Endocrinologist had not been notified.
-The MA was responsible for calling the Endocrinologist if she was not available.
-Resident #4 should have received the maximum dose of insulin and if Resident #4's blood sugar was still high the Endocrinologist should have been called per the sliding scale order.
-There was no one on-call for the Endocrinologist during the weekend.

Interview with the registered nurse (RN) for Resident #4's Endocrinologist office on 10/19/23 at 12:39pm revealed:
-The Endocrinologist had not received any calls related to Resident #4 from the facility since July 2023.
-Resident #4's last visit was 07/20/23 and was the last time the Endocrinologist had heard from anyone at the facility.
-The Endocrinologist was not aware Resident #4's FSBS were over 400 a total of 33 times from 08/01/23-10/18/23.
-The Endocrinologist had not been notified Resident #4 had received the wrong dose of insulin a total of 112 times from 08/01/23-10/17/23.
-The Endocrinologist deliberately wrote on Resident #4's SSI orders to give 0 units and call the Endocrinologist for instructions, as he wanted to know when his blood sugar was over 400.
-If Resident #4 became unresponsive he could be

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experiencing extreme hypoglycemia and would need to have 911 called if his FSBS was below 70.
-Resident #4 was at risk of a diabetic coma if his blood sugar became dangerously to high or too low.
-Resident #4 was at risk of vision problems, decreased kidney function, healing poorly, hyperglycemia, a higher risk of infection and not being able to heal from it, numbness in his hands and feet and the loss of digits or limbs and a coma and possibly death.
-He counseled Resident #4 and the staff member on the risk of high blood sugars and his desire to be notified at the 07/20/23 office visit.

2. Review of Resident #3's current FL2 dated 01/11/23 revealed diagnoses included depression, schizoaffective disorder bipolar type, acute delirium, early dementia, and borderline intellectual functioning.

Review of Resident #3's physician's order dated 01/12/23 revealed there was a medication order for venlafaxine (used to treat depression) 75mg take 1 tablet daily.

Review of Resident #3's local hospital discharge physician's orders dated 05/30/23 revealed:
-There was a medication order for sertraline (used to treat depression) 25mg take 1 tablet daily.
- There was an order to discontinue venlafaxine 75mg take 1 tablet daily.

Review of Resident #3's physician's orders report dated 09/05/23 revealed:
-There was a medication order for venlafaxine 75mg take 1 tablet daily.
-There was a medication order for sertraline

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25mg take 1 tablet daily.

Review of Resident #3's quarterly pharmacy recommendation dated 09/27/23 revealed a pharmacist recommendation to discontinue either sertraline or venlafaxine due to a potential increased risk of Resident #3 developing serotonin syndrome (a serious drug reaction caused by medications, usually combining medications that contain serotonin, that build up high levels of serotonin in the body causing signs and symptoms ranging from agitation, restlessness, confusion, rapid heart rate, high blood pressure, diarrhea, headache, fever, seizures, and/or death).

Review of Resident #3's chart notes revealed there was no documentation the primary care physician (PCP) was notified of the pharmacist recommendations.

Review of Resident #3's September 2023 medication administration record (MAR) revealed:
-There was an entry for sertraline 25mg take 1 tablet daily.
-There was documentation sertraline 25mg take 1 tablet daily was administered daily at 9:00am from 09/27/23-09/30/23.
-There was an entry for venlafaxine 75mg take 1 capsule daily.
-There was documentation venlafaxine 75mg take 1 capsule daily was administered daily at 9:00am from 09/27/23-09/30/23.

Review of Resident #3's October 2023 MAR revealed:
-There was an entry for sertraline 25mg take 1 tablet daily.
-There was documentation sertraline 25mg take 1 tablet daily was administered at 9:00am from

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10/01/23-10/08/23.
-There was documentation sertraline was not administered from 10/09/23-10/17/23 due to being hospitalized.
-There was an entry for venlafaxine 75mg take 1 capsule daily.
-There was documentation venlafaxine was administered at 9:00am from 10/01/23-10/08/23.
-There was documentation venlafaxine was not administered from 10/09/23-10/17/23 due to being hospitalized.

Interview with a medication aide (MA) on 10/17/23 at 3:45pm revealed:
-Resident #3 was acting "strange" on 10/08/23 because she was talking in a low tone of voice, asking if she was wearing the right clothes or what could she eat.
- Resident #3 was incontinent of urine and diarrhea, pulled all her clothes off in the bathroom and walked around the facility naked, acted more confused, and complained of a headache.
-She called for an ambulance around 12:15pm to send Resident #3 to the local hospital emergency room (ER) for an evaluation.
-The emergency medical service (EMS) responders said Resident #3 was experiencing psychosis (a mental disorder characterized by a disconnection from reality).

Review of Resident #3's local hospital admission history and physical report dated 10/08/23 at 10:14pm revealed:
-Resident #3 reported 3 days of increased loose stools and the "facility manager" confirmed.
-The facility "manager" reported Resident #3 had episodes of altered mental status with worsening visual hallucinations, behaviors out of the ordinary, seeing things that weren't there, and being more disruptive with staff and other

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residents residing at the facility.
-Resident #3's symptoms were most likely psychiatric in nature and did not appear to be caused by an underlying infection triggering an altered mental status.
-Home medications list included venlafaxine 75mg take 1 tablet daily and sertraline 25mg take 1 tablet daily.
-Resident #3's vital signs on 10/08/23 at 7:23pm were temperature 99.4, heart rate 80, respiration rate 25, and blood pressure 173/92.

Review of Resident #3's local hospital discharge summary dated 10/12/23 at 6:51pm revealed:
-Resident #3 was admitted on 10/08/23 at 1:11pm and was awaiting discharge to be admitted to an inpatient psychiatry unit when a bed was available.
-Venlafaxine 75mg was discontinued and sertraline 25mg take 1 tablet daily was continued.
-Resident #3 had thoughts of suicidal ideation and homicidal ideation towards a staff member at the facility upon admission to the hospital.
-Resident #3's discharge diagnoses included encephalopathy, diarrhea, and polypharmacy (the simultaneous use of multiple medications to treat conditions that increased the risk of an adverse event).

Interview with the Resident Care Coordinator (RCC)/MA on 10/18/23 at 10:30am revealed:
-She was responsible for faxing recommendations from the pharmacist to Resident #3's PCP.
-She did not know if she faxed Resident #3's pharmacist recommendation dated 09/27/23 to the PCP with the recommendation to discontinue either sertraline or venlafaxine.
-If she faxed Resident #3's pharmacist recommendation to the PCP, and did not get a

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response from the provider, she figured the PCP did not want to change Resident #3's medication orders.
-The fax machine did not provide a confirmation sheet when a document was faxed.
-She did not call to verify the fax was received or document that she faxed the recommendation.
-She had no system in place to make sure Resident #3's pharmacist recommendation was faxed to or received by the PCP.

Telephone interview with Resident #3's PCP on 10/18/23 at 4:45pm revealed:
-The facility did not fax a pharmacy recommendation dated 09/27/23 to her office for Resident #3 to discontinue either sertraline or venlafaxine.
-All faxes received at the office were scanned into a computer system and all telephone calls were documented.
-There was no documentation of any telephone calls made from the facility to the office notifying her of the pharmacist recommendation for Resident #3 or that a fax was sent or received.
-It was important for the facility to follow up and notify her of any pharmacist recommendations so that she could make medication changes if needed.
-She could see in her computer system that Resident #3 was admitted to the local hospital but had limited access to the records.
-It was possible Resident #3 was experiencing serotonin syndrome due to being administered both venlafaxine and sertraline requiring hospitalization, but she could not say for sure due to the limited access to Resident #3's hospital record.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/19/23 at

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1:05pm revealed:
-The medications venlafaxine and sertraline were not commonly prescribed together due to a risk of causing serotonin syndrome.
-Another pharmacist at the pharmacy wrote the recommendation on 09/27/23 to the PCP to discontinue either venlafaxine or sertraline .
-The facility was responsible for sending the pharmacist recommendations to Resident #3's PCP.

Interview with the Administrator on 10/20/23 at 2:55pm revealed:
-She did not know the pharmacy recommendation dated 09/27/23 for Resident #3 was not faxed to the PCP.
-The RCC was responsible for faxing pharmacist recommendations to the PCP.
-It was the responsibility of the RCC to follow up and make sure a fax was received after it was sent to the provider because the fax machine did not provide confirmations.
-She expected the RCC to fax all pharmacy recommendations to the PCP when received.

_____

The facility failed to notify Resident #4's primary care provider or endocrinologist for fingerstick blood sugars (FSBS) greater than 400 as ordered for 33 FSBS readings from 08/01/23-10/18/23 placing Resident #4 at an increased risk for vision problems, decreased kidney function, increased risk of infection with poor healing, numbness in hands and feet, or loss of digits or limbs and Resident #3's PCP was not notified of a pharmacy recommendation to discontinue 1 of 2 antidepressant medications to decrease the risk of developing serotonin syndrome and Resident #3 was sent to the local hospital on 10/08/23 with a possible diagnosis of serotonin syndrome. This failure resulted in serious physical harm and

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D 273	Continued From page 10 neglect constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/20/23 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 19, 2023.	D 273		
D 315	10A NCAC 13F .0905 (a & b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure 9 of 9 residents were offered activities designed to promote active involvement with each other and the community. The findings are: Interview with a resident on 10/17/23 at 9:10am revealed: -There were no activities. -She talked to other residents for an activity. Interview with a second resident on 10/17/23 at	D 315		

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D 315	Continued From page 11 9:10am revealed: -The facility offered "very little" activities. -He was bored most of the time because he had nothing to do. -He had no one to talk to except himself. Interview with a third resident on 10/17/23 at 9:10am revealed: -She would sleep or watch television. -There were no scheduled activities. Interview with a fourth resident on 10/17/23 at 9:10am revealed: -The facility did not provide activities even though there was a calendar with activities scheduled posted in the main hallway. -He sat outside as an activity. -They may occasionally do a game but not daily. Interview with a fifth resident on 10/17/23 at 9:20am revealed: -The facility offered an activity about once every 2 weeks such as Bingo, coloring, playing cards, or playing horseshoes. -He usually did not like the activity offered every couple of weeks because they were the same activities offered "over and over" again. -He would like new and fun activities offered because he did not like coloring, and he was bored with playing cards. -He kept himself busy by watching television in his room or completing crossword puzzles from the newspaper. Interview with a sixth resident on 10/17/23 at 9:30am revealed: -The facility did not offer any activities that he was aware of. -Occasionally the facility offered crafts, but he did not like crafts.	D 315		

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-He was bored most of the time because there was nothing to do.
-He watched television or slept when he was bored.

Observation of the facility's October 2023 activities calendar in the main hallway on 10/17/23 revealed:
-Activities listed on 10/17/23-10/20/23 included monopoly, cards, puzzles, coloring, bingo, horseshoes, making muffins, movie with popcorn and current events.
-There was one activity documented as bird watching from 11:00am-12:00pm scheduled on 10/05/23 and 10/24/23.

Observation on 10/19/23 at 9:21am revealed bingo was on the activity calendar on 10/19/23 from 9:00am to 10:00am but no one was gathered for or playing bingo.

Observation on 10/19/23 at 10:10am revealed playing horseshoes was on the activity calendar on 10/19/23 from 10:00am to 11:00am but no one was gathered to play.
-The Activities Director could not be located in the building.

Interview with a medication aide (MA) on 10/17/23 at 10:45am revealed:
-She was responsible for completing the monthly activities calendar.
-She asked the residents what they would like to do every month so she could include those activities if possible.
-There were 4 residents who participated in playing a board game, but they did not play for long.
-The board game was scheduled on 10/17/23 from 1:00pm-3:00pm but was offered to the

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residents early.
-She did not have any complaints from the residents about the activities offered.
-When asked what the "bird watching" activity scheduled on 10/05/23 and 10/24/23 from 11:00am-12:00pm included she said the residents would go outside on their own and "just watch outside" to see if they saw any birds.

Interview with one of the residents, named by the MA as participating in the activity scheduled on 10/17/23, on 10/18/23 at 9:53am revealed:
-He sat in the dining room from about 10:00am-10:30am on 10/17/23 and staff did not show up for the scheduled activity.
-He talked to 2 other residents for about 10 minutes when they showed up for the activity also and then all 3 of them left and went back to their rooms.

Interview with the Administrator on 10/20/23 at 2:55pm revealed:
-The MA was responsible for creating the monthly activities calendar and posting the calendar on the wall.
-The MAs were responsible for providing activities to residents.
-She did not know activities were not being offered to the residents or only being offered once every couple of weeks.
-Most of the residents did not want to participate in activities and just wanted to watch television or smoke cigarettes outside.
-She knew there should have been at least 14 hours of activities provided for residents weekly.
-She did not consider residents going outside and watching the air for birds to fly by an activity.

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D 338	10A NCAC 13F .0909 Resident Rights	D 338		

10A NCAC 13F .0909 Resident Rights
An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

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

Based on interviews and record reviews, the facility failed to ensure resident rights were maintained for 9 of 9 residents residing in the facility by ensuring meals were served at regular hours comparable to mealtimes in the community and bedtime medications were administered so that the residents were able to go to sleep at a reasonable hour.

The findings are:

Observation in the main hallway, kitchen, dining room, and common living room on 10/17/23 at 8:58am revealed there were no staff present.

Observation of the dining room on 10/17/23 at 8:58am revealed there were plastic containers filled with cereal setting on the dining room table with 2 plastic cups containing milk and 2 coffee mugs with coffee.

Observation of the main office on 10/17/23 at 9:00am revealed:
-The door was closed and after knocking loudly the medication aide (MA) opened the door.
-The MA answered the door and her hair looked unbrushed, and it appeared that she was awoken by the survey team.

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-The MAs bedroom was located in a separate room inside the main office.

Interview with a resident on 10/17/23 at 9:20am revealed:
-He ate cereal for breakfast around 8:30am.
-The facility offered cereal about 3 days weekly.
-The facility staff left cereal setting on the table for the residents to fix themselves a bowl.
-Another resident always made coffee for the other residents.

Interview with a second resident on 10/18/23 at 12:42pm revealed:
-The Activities Director prepared dinner last night because he told her the MA was sick and laying down in the bed.
-She knocked on the MA's door on 10/17/23 around 11:00pm and got no response so she telephoned the Resident Care Coordinator (RCC) because she had not been administered her bedtime medications, including her insulin.
-The RCC assured her she would get a hold of the MA and get the MA to administer her nightly medications.
-Her medications were administered late "a lot" when the MA worked.
-Sometimes the MA would prepare dinner around 8:00pm or 9:00pm and she did not like eating so late before going to bed.
-She was used to going to bed early.
-She did not like having to stay up so late just to make sure she was administered her medications.

Interview with a third resident on 10/20/23 at 9:33am revealed the evening meal was sometimes served at 9:00pm.

Interview with a fourth resident on 10/20/23 at

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D 338	Continued From page 16 10:20am revealed: -She did not know why the MA served meals so late. -She and the other residents were "lucky" if they were served breakfast by 10:00am. -Lunch was usually served between 2:00pm-3:00pm and dinner was sometimes not served until almost 11:00pm. -She was not used to eating her meals so late and wanted them served at normal eating times. -She was usually administered her medications around the same time the meals were served. -She did not report the MA to anyone for serving meals and medications so late because the MA was usually the only person working most of the time at the facility. -Meals were usually served at regular times when the RCC worked instead of the MA. Interview with the RCC on 10/19/23 at 10:22am revealed: -A resident called her a couple of nights ago around 10:00pm or 10:30pm and said she was not administered her nightly medications or insulin. -The resident said she knocked on the MA's door and the MA would not answer. -She telephoned the MA, who reported she was about to administer the night medications but did not say why she had not administered them to the residents yet. -She did not know why all of the residents night medications had not been administered on time. Interview with the MA on 10/20/23 at 2:30pm revealed: -She administered insulin to the residents requiring insulin at meal times which was around 8:30am-9:00am, 12:30pm-1:00pm, and 5:30pm-6:00pm.	D 338		

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-The bedtime dosages of insulin were administered between 10:00pm and 10:30pm.
-She knew the bedtime dosages were scheduled at either 8:00pm or 9:00pm.
-She only gave the bedtime dosages of insulin to the residents late once around 11:00pm a few nights ago.
-She always administered the residents scheduled or sliding scale insulin (SSI) at the same time when she checked the fingerstick blood sugars (FSBS).
-She did not know a time was recorded in the glucometer when the FSBS was checked.
-She did not know why the FSBS reading times were recorded in the glucometers so late for meal times and bedtime, with the bedtime readings ranging from 10:10pm-12:09am.

Second interview with the RCC on 10/20/23 at 10:55am revealed:
-She did not know the MA was administering medications and serving meals to the residents so late until about 2 weeks ago when one of the residents complained to her about it.
-She asked some of the residents what time meals were being served and they told her around 8:00pm or 8:30pm for dinner.
-She told the MA that meals had to be served by 9:00am, 1:00pm, and 6:30pm and that it was not acceptable to serve the meals so late.
-She had already talked to the MA a couple of times about serving the meals at the scheduled times since she was made aware by the residents of them being served so late.
-She occasionally had to remind the MA to start preparing the evening meal because she would serve it late.
-She and the Administrator had discussed the late meals after they found out they were being served late and she talked to the MA and told her

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D 338	Continued From page 18 the meals and medications were supposed to be done at the scheduled times. Interview with the Administrator on 10/20/23 at 11:51am revealed: -She was not aware that the residents were being served meals so late or that the medications were not being administered within the scheduled timeframes. -She expected the MA to serve the residents meals during normal hours for eating. -She expected the MA to administer medications at the scheduled times. The facility failed to ensure meals were served at regular hours, comparable to mealtimes in the community, and bedtime medications were administered on time resulting in the residents having to eat meals later in the day than desired and having to stay up late into the evening in order to receive their bedtime medication, was detrimental to the health of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/20/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 04, 2023.	D 338		
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	D 358		

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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 ordered for 3 of 3 sampled residents (Resident #3 and #4) related to administered an incorrect dosage of a sliding scale insulin (SSI) during a medication pass (#4), multiple instances of being administered incorrect dosages of SSI (#3 and #4), and medications used to promote sleep and prevent urinary tract infections (#3) and a medication used to assist with pain (Resident #2).

The findings are:

1. Review of Resident #4's current FL2 dated 09/20/23 revealed:
-Diagnosis included diabetes.
-There was an order for Lantus (a slow acting insulin) 15 units subcutaneous (SQ) twice daily.
-There was an order for novolog (a fast acting insulin) inject 6 units SQ with meals and at bedtime.
-There was an order for sliding scale as follows: 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, over 400 give 0 units and call the physician for instructions.

Observation of the medication pass on 10/18/23 at 12:34pm revealed:
-The medication aide (MA) donned gloves and

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checked Resident #4's fingerstick blood sugar (FSBS) with a reading of 234.
-The MA drew up 10 units (u) of novolog SSI into an insulin syringe (10 units was confirmed verbally with the MA) and she injected the 10u novolog insulin into Resident #4's right lower abdomen.

Review of Resident #4's physician's order dated 09/20/23 revealed:
-There was an order for novolog inject 6u before meals plus the SSI dose per the SSI scale.
-There was an order for novolog SSI administer 2 units novolog if the FSBS reading was 201-250.

Interview with the MA on 10/18/23 at 12:39pm revealed she thought she administered novolog 6u plus 2u novolog SSI to Resident #4 on 10/18/23 at 12:34pm.

Interview with the MA on 10/18/23 at 4:14pm revealed:
-When she administered Resident #4's insulin at lunch she used the sliding scale to determine she should administer a total of 8u but the level in the syringe was almost at the 10u mark so that is what she told the surveyor she administered when she was questioned.
-The syringe had small lines and since there was only a one line difference from 8u to 10u it was hard to tell the exact amount.

Interview with the Administrator on 10/18/23 at 1:10pm revealed:
-She thought the MA administered an incorrect dosage of novolog SSI to Resident #4 on 10/18/23 at 12:34pm on the medication pass because she "got in a hurry" because she observed the MA being in a hurry and making mistakes in the past.

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-The MA should have double checked the order to make sure she administered the correct amount of insulin to Resident #4.

b. Review of Resident #4's physician's orders dated 04/01/22 revealed:
-There was an order for Lantus 15 units subcutaneous (SQ) twice daily.
-There was an order for novolog insulin inject 6 units SQ with meals and at bedtime.
-There was an order for FSBS with a sliding scale as follows; 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, over 400 give 0 units and call the physician for instructions.

Review of Resident #4's physician's orders dated 09/25/23 revealed there was an order for Lantus 18 units subcutaneous (SQ) twice daily.

Review of Resident #4's August 2023 medication administration record (MAR) revealed:
-There was an entry for novolog insulin give 6 units three times daily and at bedtime at 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was documentation novolog 6 units was administered three times daily and bedtime at 8:00am, 12:00pm, 4:00pm and 8:00pm from 08/01/23 - 08/31/23.
-There was an entry for novolog insulin SSI three times daily before meals and bedtime at 8:00am, 12:00pm, and 4:00pm and 8:00pm with a FSBS reading 151-200=1u, 201-250=2u, 251-300=3u, 301-350=4u, 351-400=5u and if greater than 400 give 0 units and call the physician.
-There were 112 instances of the FSBS reading being 151 or greater between 08/01/23 - 08/31/23 with 51 doses of novolog SSI documented as administered incorrectly.
-There were 12 instances of the FSBS reading

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being 150 or less at 8:00pm from 08/01/23 - 08/31/23 with 12 doses of novolog SSI documented as administered incorrectly (12 of the 12 doses in the amount of 7 units novolog SSI were documented as administered when no SSI should have been administered).

Review of Resident #4's handwritten September 2023 MAR revealed:
-There was no entry for Lantus 15 units SQ twice daily 09/01/23 - 09/25/23.
-There was no entry for Lantus 18 units SQ twice daily 09/25/23 - 09/30/23.
-There was no entry for novolog insulin give 6 units three times daily and at bedtime at 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was no documentation novolog 6 units was administered three times daily and bedtime at 8:00am, 12:00pm, 4:00pm and 8:00pm from 09/01/23 - 09/30/23.
-There was no entry for novolog insulin SSI three times daily before meals and bedtime at 8:00am, 12:00pm, and 4:00pm and 8:00pm with a FSBS reading 151-200=1u, 201-250=2u, 251-300=3u, 301-350=4u, 351-400=5u and if greater than 400 give 0 units and call the physician.

Review of Resident #4's September FSBS monitoring log revealed:
-There was documentation Lantus 18 units SQ was administered twice daily 09/01/23 - 09/30/23 when Lantus 15 units SQ twice daily 09/01/23 - 09/25/23 should have been given .
-There was an entry for novolog insulin give 6 units three times daily and at bedtime at 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was documentation novolog 6 units was administered three times daily and bedtime at 8:00am, 12:00pm, 4:00pm and 8:00pm from 09/01/23 - 09/30/23.

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D 358	Continued From page 23 -There was an entry for novolog insulin SSI three times daily before meals and bedtime at 8:00am, 12:00pm, and 4:00pm and 8:00pm with a FSBS reading 151-200=1u, 201-250=2u, 251-300=3u, 301-350=4u, 351-400=5u and if greater than 400 give 0 units and call the physician. -There were 107 instances of the FSBS reading being 151 or greater between 09/01/23 - 09/30/23 with 25 doses of novolog SSI documented as administered incorrectly. -There were 13 instances of the FSBS reading being 150 or less between 09/01/23 - 09/30/23 with 10 doses of novolog SSI documented as administered incorrectly (10 of the 13 doses in the amount of 7 units novolog SSI was documented as administered when no SSI should have been administered). Review of Resident #4's October 2023 MAR revealed: -There was an entry for novolog insulin give 6 units three times daily and at bedtime at 8:00am, 12:00pm, 4:00pm and 8:00pm. -There was no documentation novolog 6 units was administered three times daily and bedtime at 8:00am, 12:00pm, 4:00pm and 8:00pm from 10/01/23 - 10/17/23. -There was a handwritten note with "in CBG (capillary blood glucose monitoring) book" written on the MAR.. -There was an entry for novolog insulin SSI three times daily before meals and bedtime at 8:00am, 12:00pm, and 4:00pm and 8:00pm with a FSBS reading 151-200=1u, 201-250=2u, 251-300=3u, 301-350=4u, 351-400=5u and if greater than 400 give 0 units and call the physician. -There was no entry for novolog insulin SSI three times daily before meals and bedtime at 8:00am, 12:00pm, and 4:00pm and 8:00pm with a FSBS reading 151-200=1u, 201-250=2u, 251-300=3u,	D 358		

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301-350=4u, 351-400=5u and if greater than 400 give 0 units and call the physician.
-On the MAR there was a handwritten note with "in CBG (capillary blood glucose monitoring) book" written on the MAR.
-There was no documentation novolog SSI was administered at 8:00am, 12:00pm, 4:00pm and 8:00pm from 09/01/23-09/30/23 and there was a handwritten note with "in CBG (capillary blood glucose monitoring) written on the MAR.

Review of Resident #4's October 2023 FSBS monitoring log revealed:
-There were 65 instances of the FSBS reading being 151 or greater between 10/01/23 - 10/17/23 with 13 doses of novolog SSI documented as administered incorrectly.
-There were 3 instances of the FSBS reading being 150 or less from 10/01/23 - 10/17/23 with 1 doses of novolog SSI documented as administered incorrectly (1 of the 3 doses in the amount of 7 units novolog SSI was documented as administered when no SSI should have been administered).

Interview with Resident #4 on 10/20/23 at 9:33am revealed:
-He has been at the local emergency department several times in the past few weeks for high blood sugar and low blood sugar.
-When his blood sugar meter read "HI" the MA administered a little extra insulin and said she would call the PCP.
-He was not aware if he had received any wrong doses of insulin.

Interview with the MA on 10/19/23 at 8:55am revealed:
-She was not aware she had given the wrong dose of insulin to Resident #4.

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-She had followed the SSI as it was ordered.
-The Resident Care Coordinator (RCC) and the facility contracted registered nurse (RN) had trained her on the SSI.
-She did not know what she was to do when Resident #4's glucometer registered "HI".
-She had not asked what she was to do when Resident #4's glucometer registered "HI".
-She had not notified the physician Resident #4 had received any incorrect dosages of insulin.

Telephone interview with the Endocrinologist's registered nurse (RN) for Resident #4 on 10/19/23 at 12:39pm revealed:
-The physician had treated Resident #4 for years and was aware his blood sugar fluctuated from very low to very high
-Resident #4's last visit was on 07/20/23.
-Resident #4 had been to the local emergency room multiple times for his blood sugars the most recent was 09/16/23 for low blood sugar.
-Resident #4 was at risk of a diabetic coma if his blood sugar became dangerously high or to low.
-Resident #4 was already at risk of vision problems, decreased kidney function, healing poorly, hyperglycemia, a higher risk of infection and not being able to heal from it, numbness in his hands and feet and the loss of digits or limbs, coma and possibly death and therefore wanted to be notified.

Telephone interview with the facility contracted RN on 10/19/23 at 3:36pm revealed:
-She did not remember the last time she had provided a diabetic training for facility staff but she did it yearly.
-She had trained the MA and had general discussions with her about administering SSI and diabetic care.
-She had not provided a detailed training for the

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MA since May of 2023.
-She had encouraged her to go slow and ensure accuracy when administering medications.
-The MA had been trained to follow the orders the physician had written and to inform the physician when there was a medication error.
-She had assisted the facility with checking the MARS with the glucometer to ensure Resident #4 FSBS was accurate on the MAR but could not recall the last time.
-She had not checked to see if Resident #4 was receiving the correct dose of insulin according to his SSI.

Interview with the Administrator on 10/20/23 at 10:23am revealed:
-She was not aware the MA had administered the wrong dose of insulin to Resident #4 in August, September and October 2023.
-She had spoken with the MA before about taking her time when giving medications.
-She should have called the physician if she knew she had given the wrong dose of insulin.
-The facility's contracted RN was supposed to be checking the medications, MARs and medication cart to ensure accuracy for residents with SSI but there was no system in place to ensure the RN had.

2. Review of Resident #1's current FL2 dated 04/20/23 revealed:
-Diagnoses included neuroleptic induced Parkinson's disease, dysphagia, bipolar disorder and hemiparesis.
-There was an order for Flexeril 10mg (used to treat pain and stiffness) one tablet twice daily as needed.

Observation of the medication pass on 10/17/23 at 3:50pm revealed there was no Flexeril 10mg

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one tablet twice daily as needed available for administration.

Interview with Resident #1 on 10/17/23 at 9:30am revealed:
-He took flexeril for lower back pain from having 2 strokes and being paralyzed on the left side.
-His back pain about a 6 or 7 on a scale of 0-10 every day.
-He was "out" of his flexeril and did not know how long it had been unavailable.
-He had been "screaming" about back pain for months and told the MA he needed his flexeril.
-The MA told him he was "out" of his flexeril and that was at least a couple of months ago.

Interview with Resident #1's power of attorney (POA) on 10/17/23 at 12:26pm revealed:
-Resident #1 complained of back pain all the time.
-She thought Resident #1 was being administered his ordered flexeril for the back pain.
-Resident #1 told her today that he had not received his flexeril in months.

Interview with the Administrator on 10/17/23 at 1:10pm revealed:
-She was not aware Resident #1 did not have flexeril available for administration.
-The medication should have been in the facility and available for administration.

Interview with the Resident Care Coordinator (RCC) on 10/17/23 at 1:15pm revealed:
-Resident #1 had seen the physician on 10/16/23.
-Resident #1 had been complaining about back pain but did not recall him asking for his flexeril.
-She did not recall the last time Resident #1 had flexeril available for administration but it had been

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D 358	Continued From page 28 a long time. Interview with the MA on 10/17/23 at 4:15pm revealed: -She was not aware Resident #1 was experiencing back pain until 10/16/23 when he asked for his flexeril. -The facility had to call the local veterans administration medical center (VAMC) pharmacy for his flexeril. -She had been employed by the facility since October of 2022 and she had never ordered flexeril for Resident #1. -She said Resident #1 had never asked for his flexeril. -She had to call the local VAMC pharmacy for Resident #1's PRN medication. -She stated she had called the local VAMC pharmacy multiple times for Flexeril but had no documentation to show she had called. -The facility did not have a back up pharmacy to obtain the flexeril. -If Resident #1 ran out of his medications he "was just out" of it until the medication was mailed from the local VAMC pharmacy. 3. Review of Resident #3's current FL2 dated 01/11/23 revealed: -Diagnoses included diabetes mellitus type 2, history of urinary tract infections (UTIs), and sleep disorder. -There was a medication order for lispro sliding scale insulin (used to treat high blood sugar levels) before meals if the finger stick blood sugar (FSBS) was 151-200=1 unit (u), 201-250=2u, 251-300=3u, 301-350=5u, 351-400=7u and at bedtime if the FSBS was 151-200=0 units, 201-250=1u, 251-300=2u, 301-350=3u, 351-400=5u, and melatonin (used to promote sleep) 3mg take 1 tablet at bedtime.	D 358		

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D 358	Continued From page 29 a. Review of Resident #3's physician's order dated 09/05/23 revealed an order for lispro give 3 units before meals and lispro sliding scale insulin (SSI) before meals if the finger stick blood sugar (FSBS) was 151-200=1u, 201-250=2u, 251-300=3u, 301-350=5u, 351-400=7u and at bedtime if the FSBS was 151-200=0 units, 201-250=1u, 251-300=2u, 301-350=3u, 351-400=5u. Review of Resident #3's August 2023 medication administration record (MAR) revealed: -There was an entry for lispro insulin give 3 units three times daily at 6:30am, 11:30am, and 4:30pm. -There was documentation lispro 3u was administered three times daily at 6:30am, 11:30am, and 4:30pm from 08/01/23 - 08/31/23. -There was an entry for lispro SSI three times daily before meals at 8:00am, 12:00pm, and 5:00pm with a FSBS reading 151-200=1u, 201-250=2u, 251-300=3u, 301-350=5u, 351-400=7u. -There were 16 instances of the FSBS reading being 151 or greater between 08/01/23 - 08/31/23 with 16 doses of lispro SSI documented as administered incorrectly. -There was a FSBS reading documented as 107 on 08/31/23 at 12:00pm and 2u of lispro SSI were administered when 0 units should have been given. -There was an entry for lispro SSI at 8:00pm with a FSBS reading 151-200=0 units, 201-250=1u, 251-300=2u, 301-350=3u, 351-400=5u. -There were 23 instances of the FSBS reading being 150 or less at 8:00pm from 08/01/23 - 08/31/23 with 23 doses of lispro SSI documented as administered incorrectly (21 of the 23 doses in the amount of 9u lispro SSI was documented as	D 358		

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administered when no SSI should have been given).
-There were 7 instances of the FSBS reading being 150 or greater from 08/01/23 - 08/31/23 with 7 doses of lispro SSI documented as administered incorrectly.

Review of Resident #3's September 2023 MAR revealed:
-There was an entry for lispro insulin give 3 units three times daily at 9:00am, 2:00pm and 9:00pm.
-There was documentation lispro 3u was administered three times daily at 9:00am, 2:00pm, and 9:00pm.
-There was an entry for lispro SSI three times daily before meals at 8:00am, 12:00pm, and 5:00pm with a FSBS reading 151-200=1u, 201-250=2u, 251-300=3u, 301-350=5u, 351-400=7u.
-There was no documentation lispro SSI was administered at 8:00am, 12:00pm, and 5:00pm from 09/01/23-09/30/23 and there was a handwritten note with "see FSBS book in insulin room" written on the MAR.
-There was an entry for lispro SSI at 8:00pm with a FSBS reading 151-200=0 units, 201-250=1u, 251-300=2u, 301-350=3u, 351-400=5u.
-There was no documentation lispro SSI was administered at 8:00pm from 09/01/23-09/30/23 and there was a handwritten note with "see FSBS book in insulin room" written on the MAR.

Review of Resident #3's September 2023 FSBS monitoring log revealed:
-There was no lispro SSI scale documented on the FSBS monitoring log.
-There were 31 instances of the FSBS reading being 151 or greater at 8:00am, 12:00pm, and 5:00pm from 09/01/23-09/30/23 and 4 doses of lispro SSI were documented as administered

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incorrectly.
-There were 3 instances of the FSBS reading being 201 or greater at 8:00pm with 3 doses of lispro SSI documented as administered incorrectly.
-There were 4 instances of the FSBS reading being 200 or less at 8:00pm with 4 doses of lispro SSI documented as administered when there should have been no SSI given.

Review of Resident #3's 10/01/23-10/17/23 MAR revealed:
-There was an entry for lispro insulin give 3 units three times daily at 9:00am, 2:00pm and 9:00pm.
-There was no documentation lispro 3u was administered three times daily at 9:00am, 2:00pm, and 9:00pm and there was a handwritten note with "see FSBS book" written on the MAR.
-There was an entry for lispro SSI three times daily before meals at 8:00am, 12:00pm, and 5:00pm with a FSBS reading 151-200=1u, 201-250=2u, 251-300=3u, 301-350=5u, 351-400=7u.
-There was no documentation lispro SSI was administered at 8:00am, 12:00pm, and 5:00pm from 10/01/23-10/17/23 and there was a handwritten note with "see FSBS book in insulin room" written on the MAR.
-There was an entry for lispro SSI at 8:00pm with a FSBS reading 151-200=0 units, 201-250=1u, 251-300=2u, 301-350=3u, 351-400=5u.
-There was no documentation lispro SSI was administered at 8:00pm from 10/01/23-10/17/23 and there was a handwritten note with "see FSBS book in insulin room" written on the MAR.

Review of Resident #3's 10/01/23-10/08/23 FSBS monitoring log revealed:
-There was a handwritten entry for lispro inject 3 units three times a day at breakfast, lunch, and

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D 358	Continued From page 32 dinner (no times documented) and lispro SSI three times a day at breakfast, lunch, and dinner (no times documented) with a FSBS scale 151-200=1u, 201-250=2u, 251-300=3u, 301-350=5u, 351-400=7u, and lispro SSI at bedtime (no time documented) with a FSBS scale 151-200=0u, 201-250=1u, 251-300=2u, 301-350=3u, 351-400=5u. -There was no documentation lispro 3u was administered at 9:00am, 2:00pm, and 9:00pm from 10/01/23-10/08/23. -There were 4 instances of the FSBS reading being 151 or greater at 9:00am, 2:00pm, and 9:00pm from 10/01/23-10/07/23 and 9:00am on 10/08/23 with 4 doses of lispro SSI documented as administered incorrectly. -There was 1 instance of the FSBS reading being 201 or greater from 10/01/23-10/08/23 at bedtime and 1 dose of lispro SSI was documented as administered incorrectly. -There was documentation Resident #3 was admitted to the local hospital on 10/09/23 and there were no other FSBS readings, lispro 3u, or lispro SSI documented on the FSBS monitoring log after breakfast on 10/08/23. Observation of Resident #3's medications on hand on 10/18/23 at 11:15am revealed lispro 100units/ml pen was available for administration. Interview with a pharmacy technician from the facility's contracted pharmacy on 10/18/23 at 3:25pm revealed: -Resident #3's lispro pen was last dispensed on 10/06/23. -The pharmacy added the entries for medications to the MAR and delivered the MARs to the facility monthly.	D 358		

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D 358	Continued From page 33 Interview with a medication aide (MA) on 10/17/23 at 3:39pm revealed: -She was the MA who administered Resident #3's insulin on 08/31/23. -She administered 2 units of insulin on 08/31/23 at 12:00pm. -She could not read her handwriting to determine how much insulin should have been administered on 08/31/23 at 12:00pm. -The reason the facility started documenting in September 2023 all information about FSBS on a separate paper (FSBS monitoring log) was because they were not able to clearly document in the small space provided on the MAR. -No matter what number she guessed the reading was on 08/30/23 at 12:00pm, 2 units of insulin would have been incorrect. -Resident #3's SSI was changed "not long ago", and she administered the incorrect amount of SSI to Resident #3 because she referred to a copy of the old SSI scale that was posted in the insulin room. -She was taught by the RCC to use the paper copy of the SSI posted on the wall in the insulin room to administer the dosage of insulin to Resident #3 and she did not refer to the SSI scale printed on Resident #3's MAR. -The RCC was responsible to update the SSI scale posted on the wall in the insulin room when the SSI scale was changed by the provider. Interview with the RCC/MA on 10/18/23 at 10:30am revealed: -She was away from the facility August 2023 and 2 weeks in September 2023. -There was only one MA working during the time she was out of work. -She completed a MAR audit for Resident #3 monthly since May 2023 including August 2023, September 2023, and 10/01/23-10/08/23 when	D 358		

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Resident #3 was sent to the hospital to make sure the correct amount of insulin was administered to Resident #3 and found no errors.
-She thought she missed the errors on Resident #3's MARs for the incorrect amount of insulin administered in August 2023, September 2023, and 10/01/23-10/08/23 because she referred to an incorrect SSI scale posted on the wall in the insulin room.
-She was responsible for making sure the MARs and SSI scale were updated and/or correct when a new order was received.
-She did not know why she did not "catch" the SSI scale posted on the wall in the insulin room was incorrect.

Telephone interview with the PCP on 10/18/23 at 4:45pm revealed:
-She last saw Resident #3 on 06/12/23 and discussed extensively with Resident #3 and the RCC the importance of receiving the correct amount of insulin and the amount of insulin to be administered.
-Receiving too much insulin could cause Resident #3 to go into a diabetic coma or cause death.
-She expected the facility to administer Resident #3's insulin as ordered and to notify her of any medication errors so that new orders could be given.

Telephone interview with the facility's contracted registered nurse (RN) on 10/19/23 at 3:37pm revealed:
-She visited the facility twice monthly to complete various tasks.
-She completed an in-depth training with the MA and RCC/MA in May 2023 and went over checking FSBS, how to read the SSI scale with how much insulin to administer, how to give injections, and documenting the amount of insulin

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administered on the MAR.
-When she completed the training in May 2023, she gave the MAs scenarios of an example FSBS reading and asked them how much insulin should be given and the MAs were able "talk it through" to answer with the correct amount, so she did not understand why they were still administering the incorrect amount of insulin.
-The MAs found it too difficult to read and document on the MARs, so she made up the FSBS monitoring log for them to use.
-She completed education with the MAs regarding checking FSBS, reading the SSI scale, and medication administration with documentation every time she visited the facility.
-She completed MAR audits, medication cart audits to make sure medications were available and not expired, and checked new medication orders with the MARs to make sure the MARs were correct when needed but had not completed one recently and she rotated which residents she completed the audits for.
-She did not remember when she last completed a MAR audit for Resident #3.

Interview with the Administrator on 10/17/23 at 10:22am revealed:
-She did not know the MAs were referring to an old SSI scale posted in the insulin room to administer insulin to Resident #3.
-The MAs documented FSBS and the amount of insulin administered on the MAR in September 2023 but they had a difficult time writing the FSBS values in the box provided on the MAR, so she made up a FSBS and insulin log for the MAs to document on instead, beginning September 2023.
-She implemented using the FSBS and insulin log to keep all the insulin and FSBS documented for a resident on one piece of paper.

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-The facility's contracted RN visited the facility every 2 weeks and completed a MAR audit to make sure Resident #3's insulin was being administered correctly.
-She and the RCC checked Resident #3's MARs at least monthly to make sure the correct amount of insulin was being administered to Resident #3 and she thought the correct amount was being administered.
-She expected the MAs to administer Resident #3's insulin as ordered.

b. Review of Resident #3's physician's orders dated 07/18/23 revealed an order for a cranberry supplement (used to prevent urinary tract infections) take 1 tablet daily.

Review of Resident #3's physician's orders dated 09/05/23 revealed an order for a cranberry supplement take 1 tablet daily.

Review of Resident #3's August 2023 medication administration record (MAR) revealed:
-There was an entry for cranberry supplement take 1 tablet daily.
-There was documentation a cranberry tablet was administered daily at 9:00am from 08/01/23-08/31/23.

Review of Resident #3's September 2023 MAR revealed:
-There was an entry for cranberry supplement take 1 tablet daily.
-There was documentation a cranberry tablet was administered daily at 9:00am from 09/01/23-09/31/23 (there were 30 days in September 2023).

Review of Resident #3's October 2023 MAR revealed:

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 37 -There was an entry for cranberry supplement take 1 tablet daily. -There was documentation a cranberry tablet was administered daily at 9:00am from 10/01/23-10/08/23. -There was documentation a cranberry tablet was not administered daily at 9:00am from 10/09/23-10/17/23 due to Resident #3 being in the local hospital. Observation of medications on hand on 10/18/23 at 11:27am revealed there was no cranberry supplement available for administration. Interview with a medication aide (MA) on 10/18/23 at 11:38am revealed: -She did not know why Resident #3's cranberry supplement was not available to administer or when the medication ran out. -All of Resident #3's medications were dispensed by the facility's contracted pharmacy. -She did not know when the cranberry supplement for Resident #3 was last dispensed or requested to be refilled. -The cranberry supplement must have been available for administration because she documented she administered it to Resident #3. -The facility did not have a backup pharmacy. Telephone interview with a pharmacy technician for the facility's contracted pharmacy on 10/18/23 at 3:25pm revealed: -Resident #3's cranberry supplement was last dispensed on 05/16/23 in the quantity of 30 tablets and would last 30 days if administered as written. -The pharmacy had not received a refill request for Resident #3's cranberry supplement since it was last dispensed on 05/16/23.	D 358		

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Interview with the medication cycle fill coordinator at the facility's contracted pharmacy on 10/19/23 at 4:49pm revealed:
-When a medication was filled for the first time, a box needed to be checked indicating that the medication should be sent out with each monthly cycle fill.
-When Resident #3's cranberry supplement was initially filled, the box was accidentally left unchecked so the medication was never included with the cycle fill.
-Someone at the facility should have contacted the pharmacy when they noticed the medication was not delivered with the monthly cycle fill.

Interview with the Resident Care Coordinator (RCC) on 10/18/23 at 4:28pm revealed:
-She thought Resident #3 had cranberry available or she would not have documented that she administered it.
-She always signed the MAR at the same time she administered medications.
-Cranberry was a routine medications and should be delivered monthly with the pharmacy cart fill.

Telephone interview with Resident #3's primary care provider (PCP) on 10/18/23 at 4:45pm revealed:
-She ordered the cranberry supplement for Resident #3 due to Resident #3's history of urinary tract infections (UTI).
-The cranberry supplement would help to prevent future UTIs.
-By Resident #3 not receiving the cranberry supplement it could increase the risk of Resident #3 developing another UTI.

Second interview with a MA on 10/19/23 at 9:13am revealed:
-She remembered administering Resident #3's

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cranberry tablet daily during the month of August 2023, September 2023, and 10/01/23-10/08/23.
-She did not know how Resident #3's cranberry supplement was available to administer when it should have run out in June 2023 if the cranberry supplement was administered as ordered.
-She or the RCC/MA were responsible for sending medication refill requests to the pharmacy when medications were low on supply.

Telephone interview with the facility's contracted registered nurse (RN) on 10/19/23 at 3:37pm revealed:
-She completed medication cart audits randomly by rotating the residents or when the facility requested a cart audit.
-The last thorough cart audit completed was in May 2023.
-She compared the MARs to the medications available on the cart.
-She did not know the date for the last medication cart audit completed for Resident #3.
-The facility was responsible for making sure all medications ordered for residents were available to administer.

Interview with the Administrator on 10/20/23 at 2:55 pm revealed:
-She did not know Resident #3 did not have the cranberry supplement available for administration.
-The MA and RCC/MA were responsible for requesting refills for medications.
-There was no system in place to make sure medication refills were requested in a timely manner.
-The facility's contracted RN visited the facility every 2 weeks, and she thought the nurse completed medication cart audits every time to make sure all the resident's medications were

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available.
-She expected the MAs to request medication refills from the facility's contracted pharmacy when there were a few days left of the medication supply so that the supply did not run out.

c. Review of Resident #3's hospital discharge medication orders dated 05/31/23 revealed an order change for melatonin (used to promote sleep) 3mg take 2 tablets at bedtime.

Review of Resident #3's physician's order dated 09/05/23 revealed an order for melatonin 3mg take 2 tablets at bedtime.

Review of Resident #3's August 2023 medication administration record (MAR) revealed:
-There was an entry for melatonin 3mg take 2 tablets at bedtime.
-There was documentation melatonin was administered daily at 9:00pm from 08/01/23-08/31/23.

Review of Resident #3's September 2023 MAR revealed:
-There was an entry for melatonin 3mg take 2 tablets at bedtime.
-There was documentation melatonin was administered daily at 9:00pm from 09/01/23-09/31/23 (there were 30 days in September 2023).

Review of Resident #3's October 2023 MAR revealed:
-There was an entry for melatonin 3mg take 2 tablets at bedtime.
-There was documentation melatonin was administered daily at 9:00pm from 10/01/23-10/07/23.
-There was documentation melatonin was not

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administered daily at 9:00pm from 10/08/23-10/17/23 due to Resident #3 being in the local hospital.

Observation of medications on hand on 10/18/23 at 11:27am revealed there was no melatonin available for administration.

Interview with a medication aide (MA) on 10/18/23 at 11:38am revealed:
-She did not know why Resident #3's melatonin was not available to administer or when the medication ran out.
-All of Resident #3's medications were dispensed by the facility's contracted pharmacy.
-She did not know when the melatonin for Resident #3 was last dispensed or requested to be refilled.
-Resident #3's melatonin must have been available for administration because she documented she administered it to Resident #3.
-The facility did not have a backup pharmacy.

Telephone interview with a pharmacy technician for the facility's contracted pharmacy on 10/18/23 at 3:25pm revealed:
-Resident #3's melatonin 3mg was last dispensed on 06/01/23 in the quantity of 30 tablets and would last 30 days if administered as ordered.
-The facility did not fax a new order to change Resident #3's melatonin 3mg from 1 tablet at bedtime to 2 tablets at bedtime.
-If there was a new order to administer melatonin 3mg take 2 tablets at bedtime, then the quantity dispensed on 06/01/23 would have only lasted for 15 days.
-The pharmacy had not received a refill request for Resident #3's melatonin since it was last dispensed on 06/01/23.

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Interview with the medication cycle fill coordinator at the facility's contracted pharmacy on 10/19/23 at 4:49pm revealed:
-When a medication was filled for the first time, a box needed to be checked indicating that the medication should be sent out with each monthly cycle fill.
-When Resident #3's melatonin was initially filled, the box was accidentally left unchecked so the medication was never included with the cycle fill.
-Someone at the facility should have contacted the pharmacy when they noticed the medication was not delivered with the monthly cycle fill.

Interview with the Resident Care Coordinator (RCC) on 10/18/23 at 4:28pm revealed:
-She thought Resident #3 had melatonin available or she would not have documented that she administered it.
-She always signed the MAR at the same time she administered medications.
-Melatonin was a routine medication and should be delivered monthly with the pharmacy cart fill.

Interview with a MA on 10/19/23 at 9:13am revealed:
-She did not remember if she administered Resident #3's melatonin during the month of August 2023, September 2023, and 10/01/23-10/08/23.
-She thought she administered melatonin nightly at bedtime because she documented that she administered the melatonin.
-She or the RCC/MA were responsible for sending medication refill requests to the pharmacy when medications were low on supply.
-The RCC/MA was responsible for faxing new medication orders to the pharmacy.

Interview with the RCC/MA on 10/19/23 at

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D 358	Continued From page 43 10:22am revealed: -She did not remember if she faxed Resident #3's hospital discharge medication orders with the order to administer Resident #3's melatonin 3mg take 2 tabs at bedtime to the pharmacy on 05/31/23. -She did not know when Resident #3's melatonin was last requested to be refilled from the pharmacy or when it was last dispensed. Telephone interview with Resident #3's primary care provider (PCP) on 10/18/23 at 4:45pm revealed: -She ordered Resident #3 melatonin because Resident #3 was having a hard time going to sleep. -It was important for Resident #3 to receive the ordered melatonin to aide in Resident #3 getting enough sleep to optimize health. Telephone interview with the facility's contracted registered nurse (RN) on 10/19/23 at 3:37pm revealed: -She completed medication cart audits randomly by rotating the residents or when the facility requested a cart audit. -The last thorough cart audit completed was in May 2023. -She compared the MARs to the medications available on the cart. -She did not know the date for the last medication cart audit completed for Resident #3. -The facility was responsible for making sure all medications ordered for residents were available to administer. Interview with the Administrator on 10/20/23 at 2:55 pm revealed: -She did not know Resident #3 did not have melatonin available for administration.	D 358		

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D 358	Continued From page 44 -The MA and RCC/MA were responsible for requesting refills for medications. -There was no system in place to make sure medication refills were requested in a timely manner. -The facility's contracted RN visited the facility every 2 weeks, and she thought the nurse completed medication cart audits every time to make sure all the resident's medications were available. -She expected the MAs to request medication refills from the facility's contracted pharmacy when there were a few days left of the medication supply so that the supply did not run out. Attempted interview with Resident #3 on 10/17/23 upon initial tour at the facility was unsuccessful due to hospitalization. _____ The facility failed to administer Resident #4's sliding scale insulin (SSI) as ordered for a total of 112 times, from 08/01/23 -10/17/23, causing hospitalization with low blood sugar levels and administered 4 units novolog SSI on the medication pass instead of the ordered 2 units SSI, Resident #1 who was not administered a medication to treat back pain, and Resident #3 who was administered 27 doses of SSI when no insulin should have been administered, and 27 instances of incorrect dosages of SSI administered during August 2023, September 2023, and 10/01/23-10/08/23 placing Resident #3 at risk of going into a diabetic coma or death. 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 10/18/23 for this violation.	D 358		

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D 358	Continued From page 45 THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 19, 2023.	D 358		
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to ensure medications were administered within one hour before or after the prescribed time for 2 of 2 sampled residents related to insulin (Resident #4) and insulin and Finger Stick Blood Sugar (FSBS) (Resident #5). The findings are: 1. Review of Resident #4's current FL2 dated 09/20/23 revealed: -Diagnosis included diabetes. -There was an order for Lantus (a slow acting insulin) 15 units subcutaneous (SQ) twice daily. -There was an order for novolog (a fast acting insulin) inject 6 units SQ with meals and at bedtime. -There was an order for sliding scale as follows; FSBS: 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, over 400 give 0 units and call the physician for instructions.	D 364		

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Review of Resident #4's September 2023 medication administration record (MAR) revealed there was an entry for FSBS at 8:00am, 12:00pm, 4:00pm and 8:00pm with a handwritten note to "see FSBS monitoring log".

Review of Resident #4's September 2023 FSBS monitoring log revealed FSBS times were documented at breakfast, lunch, supper and bedtime, with no specific time indicated.

Review of Resident #4's October 2023 medication administration record (MAR) revealed there was an entry for FSBS at 8:00am, 12:00pm, 4:00pm and 8:00pm with a handwritten note to "see FSBS monitoring log".

Review of Resident #4's October 2023 FSBS monitoring log revealed FSBS times were documented at breakfast, lunch, supper and bedtime, with no specific time indicated.

Review of Resident #4's glucometer revealed:
-The time was 26 minutes behind when the meter was turned on.
-The date was correct when the meter was turned on.
-The glucometer documented a 33-day history, back to 09/15/23 at 10:36pm.
-The 8:00am FSBS on 10/05/23 was 144 documented at 8:28am.
-The 12:00pm FSBS on 10/05/23 was 352 documented at 1:50pm.
-The 4:00pm FSBS on 10/05/23 was 259 documented at 6:41pm
-The 8:00pm FSBS on 10/05/23 was 144 documented at 9:26pm
-The 8:00am FSBS on 10/06/23 was 245 documented at 8:58am.
-The 12:00pm FSBS on 10/06/23 was 276

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documented at 1:39pm.
-The 4:00pm FSBS on 10/06/23 was 227 documented at 7:01pm.
-The 8:00pm FSBS on 10/06/23 was 300 documented at 9:19pm.
-The 8:00am FSBS on 10/07/23 was 321 documented at 9:58am.
-The 12:00pm FSBS on 10/07/23 was 346 documented at 1:57pm
-The 4:00pm FSBS on 10/07/23 was 185 documented at 8:59pm.
-The 8:00pm FSBS on 10/07/23 was 360 documented at 10:37pm.
-The 8:00am FSBS on 10/08/23 was 451 documented at 8:00am.
-The 12:00pm FSBS on 10/08/23 was 201 documented at 1:39pm.
-The 4:00pm FSBS on 10/08/23 was 214 documented at 8:02pm.
-The 8:00pm FSBS on 10/08/23 was 396 documented at 10:55pm
-The 8:00am FSBS on 10/09/23 was 392 documented at 8:26am.
-The 12:00pm FSBS on 10/09/23 was 329 documented at 2:10pm.
-The 4:00pm FSBS on 10/09/23 was 363 documented at 8:02pm.
-The 8:00pm FSBS on 10/09/23 was HI documented at 10:17pm.
-BS taken again on 10/09/23 was 467 at 11:04pm.
-The 8:00am FSBS on 10/10 /23 was 372 documented at 8:47am.
-The 12:00pm FSBS on 10/10/23 was 259 documented at 1:12pm.
-The 4:00pm FSBS on 10/10/23 was 169 documented at 9:06pm.
-The 8:00pm FSBS on 10/10/23 was 383 documented at 10:51pm.
-The 8:00am FSBS on 10/11/23 was 380

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documented at 9:28am
-The 12:00pm FSBS on 10/11/23 was 314 documented at 1:36pm.
-The 4:00pm FSBS on 10/11/23 was 178 documented at 8:33pm.
-The 8:00pm FSBS on 10/11/23 was 352 documented at 11:25pm
-The 8:00am FSBS on 10/12/23 was 364 documented at 9:41am.
-The 12:00pm FSBS on 10/12/23 was not documented.
-The 4:00pm FSBS on 10/12/23 was 314 documented at 7:57pm.
-The 8:00pm FSBS on 10/12 /23 was 193 documented at 9:45pm.
-The 8:00am FSBS on 10/13/23 was 308 documented at 9:44am.
-The 12:00pm FSBS on 10/13/23 was 253 documented at 1:25pm.
-The 4:00pm FSBS on 10/13/23 was 169 documented at 6:41pm.
-The 8:00pm FSBS on 10/13/23 was 248 documented at 9:53pm.
-The 8:00am FSBS on 10/14/23 was 258 documented at 9:28am.
-The 12:00pm FSBS on 10/14/23 was 174 documented at 2:07pm.
-The 4:00pm FSBS on 10/14/23 was 83 documented at 8:47pm.
-The 8:00pm FSBS on 10/14/23 was 451 documented at 11:15pm.
-The 8:00am FSBS on 10/15/23 was 143 documented at 8:41am.
-The 12:00pm FSBS on 10/15/23 was HI documented at 1:37pm.
-The 4:00pm FSBS on 10/15/23 was 58 documented at 8:13pm.
-The 8:00pm FSBS on 10/15/23 was 311 documented at 11:08pm.
-The 8:00am FSBS on 10/16/23 was 282

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documented at 8:34am.
-The 12:00pm FSBS on 10/16/23 was 227 documented at 11:57am.
-The 4:00pm FSBS on 10/16/23 was 398 documented at 8:23pm.
-The 8:00pm FSBS on 10/16/23 was 356 documented at 10:53pm.
-The 8:00am FSBS on 10/17/23 was 257 documented at 8:42am.
-The 12:00pm FSBS on 10/17/23 was 156 documented at 12:30pm.
-The 4:00pm FSBS on 10/17/23 was not documented.
-The 8:00pm FSBS on 10/17/23 was HI documented at 10:58pm.
-There was documentation on the glucometer for a FSBS on 09/16/23 was 38 at 3:18pm, 84 at 3:48pm, 245 at 5:00pm with no other FSBS documented when Resident #4 went to the ED for hypoglycemia.

Interview with the Endocrinologist's registered nurse (RN) for Resident #4 on 10/19/23 at 12:39pm revealed:
-Resident #4 should have 4-5 hours in between doses of insulin.
-Resident #4 was at risk of vision problems, decreased kidney function, healing poorly, hyperglycemia, a higher risk of infection and not being able to heal from it, numbness in his hands and feet and the loss of digits or limbs, coma and possibly death and therefore wanted to be notified.

Telephone interview with the Power of Attorney for Resident #4 on 10/20/23 at 1:02pm revealed:
-Resident #4 had called her because he was not feeling well.
-She arrived at facility and transported him to the local hospital ED.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDWOOD ASSISTED LIVING	6 WINDWOOD DRIVE CANDLER, NC 28715

(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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-Resident #4 was treated and released for low blood sugar.
-Resident #4 had fluctuating blood sugars from very high to very low.
-It was important for him to receive his insulin about the same time each day as it helped regulate his blood sugar.
-She was not aware of late blood sugar checks, any wrong doses administered or receiving his insulin late.

Interview with the Resident Care Coordinator (RCC) on 10/18/23 at 4:28pm and 10/20/23 at 10:56am revealed:
-She always documented on the MAR at the same time she administered medications.
-She taught the medication aide (MA) to sign the MAR at the same time she administered medications.
-The first she knew of late medications or FSBS's was when she was informed by a resident a few weeks ago that her evening dose of insulin was being administered late in the evening.
-She was aware Resident #4 had fluctuating blood sugars.

Refer to interview with the RCC on 10/19/23 at 10:22am.

Refer to interview with a medication aide (MA) on 10/20/23 at 2:30pm.

Refer to interview with the Administrator on 09/20/23 at 10:23am revealed:

2. Review of Resident #5's current FL2 dated 05/04/23 revealed diagnoses included major depressive disorder, hypertension, diabetes and gastro-esophageal reflux disease (GERD).

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D 364	Continued From page 51 Interview with Resident #5 on 10/18/23 at 12:42pm revealed: -She knocked on the medication aide (MA)'s door on 10/17/23 around 11:00pm and got no response so she telephoned the Resident Care Coordinator (RCC) because she had not been administered her bedtime medications including her insulin. -The RCC assured her she would get ahold of the MA and get the MA to administer her nightly medications. -Her medications were administered late "a lot" when the MA worked. -Sometimes the MA would prepare dinner around 8:00pm or 9:00pm and would administer the evening insulin and bedtime medications at the same time, but would not administer the actual bedtime dose of insulin at a later time because the MA would go to bed. a. Review of Resident #5's physician orders revealed a 06/20/23 order for lantus, 22 units twice a day (used to treat diabetes). Review of Resident #5's September 2023 medication administration record (MAR) revealed there was an entry for lantus, 22 units twice a day at 6:30am and 4:30pm with a handwritten note to "see FSBS monitoring log". Review of Resident #5's September 2023 FSBS monitoring log revealed: -The lantus was documented as two times daily with no specific time indicated. -Resident #5's lantus was documented as administered at bedtime rather than at 4:30pm from 09/01/23 - 09/26/23 and from 09/29/23 - 09/31/23.	D 364		

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Review of Resident #5's October 2023 medication administration record (MAR) revealed there was an entry for lantus, 22 units twice a day at 6:30am and 4:30pm with a handwritten note to "see FSBS monitoring log" and the times were changed to 9:00am and 6:00pm.

Review of Resident #5's October 2023 FSBS monitoring log revealed:
-The lantus was documented as two times daily with no specific time indicated.
-Resident #5's lantus was documentated as administered at bedtime rather than at 4:30 pm or 6:00pm from 10/01/23 - 10/17/23.

Refer to interview with the RCC on 10/19/23 at 10:22am.

Refer to interview with the Administrator on 10/20/23 at 10:23am.

Refer to interview with a medication aide (MA) on 10/20/23 at 2:30pm.

b. Review of Resident #5's physician orders revealed a 07/05/23 order for finger stick blood sugar (FSBS) 4 times a day.

Review of Resident #5's September 2023 medication administration record (MAR) revealed there was an entry for FSBS at 8:00am, 12:00pm, 6:00pm and 10:00pm with a handwritten note to "see FSBS monitoring log" and the 8:00am time was changed to 9:00am.

Review of Resident #5's September 2023 FSBS monitoring log revealed FSBS times were documented at breakfast, lunch, supper and bedtime, with no specific time indicated.

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D 364	Continued From page 53 Review of Resident #5's October 2023 medication administration record (MAR) revealed there was an entry for FSBS at 8:00am, 12:00pm, 6:00pm and 10:00pm with a handwritten note to "see FSBS monitoring log" and the 8:00am time was changed to 9:00am. Review of Resident #5's October 2023 FSBS monitoring log revealed FSBS times were documented at breakfast, lunch, supper and bedtime, with no specific time indicated. Review of Resident #5's glucometer revealed: -The time and date were correct when the meter was turned on. -The glucometer documented a 10-day history, back to 10/08/23 at 10:08pm. -The 12:00pm FSBS on 10/09/23 was documented at 2:40pm. -The 6:00pm FSBS on 10/09/23 was documented at 8:31pm. -The 10:00pm FSBS on 10/09/23 was documented at 11:38pm. -The 12:00pm FSBS on 10/10/23 was documented at 1:39pm. -The 6:00pm FSBS on 10/10/23 was documented at 9:31pm -The 10:00pm FSBS on 10/10/23 was documented at 11:21pm. -The 12:00pm FSBS on 10/11/23 was documented at 2:03pm. -The 6:00pm FSBS on 10/11/23 was documented at 9:03pm. -The 10:00pm FSBS on 10/11/23 was documented at 11:56pm. -The 9:00am FSBS on 10/12/23 was documented at 10:13am. -The 12:00pm FSBS on 10/12/23 was documented at1:53pm. -The 6:00pm FSBS on 10/12/23 was	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 364	Continued From page 54 documented at 8:29pm. -The 12:00pm FSBS on 10/13/23 was documented at 1:56pm. -The 6:00pm FSBS on 10/13/23 was documented at 7:12pm. -The 12:00pm FSBS on 10/14/23 was documented at 2:41pm. -The 6:00pm FSBS on 10/14/23 was documented at 9:11pm. -The 10:00pm FSBS on 10/14/23 was documented at11:46pm. -There was no documentation of a 9:00am FSBS on 10/15/23. -The 12:00pm FSBS on 10/15/23 was documented at 2:09pm. -The 6:00pm FSBS on 10/15/23 was documented at 8:43pm. -The 10:00pm FSBS on 10/15/23 was documented at 11:39pm. -The 6:00pm FSBS on 10/16/23 was documented at 8:50pm. -The 10:00pm FSBS on 10/16/23 was documented at 11:25pm. -There was no documentation of a 12:00pm or 6:00pm FSBS on 10/17/23. -The 10:00pm FSBS on 10/17/23 was documented at 11:23pm. -The 6:00pm FSBS on 10/18/23 was documented at 8:46pm. -The 10:00pm FSBS on 10/18/23 was documented at 12:09am on 10/19/23. Interview with the Resident Care Coordinator (RCC) on 10/18/23 at 4:28pm and 10/20/23 at 10:56am revealed: -She always signed the MAR at the same time she administered medications. -She taught the medication aide (MA) to sign the MAR at the same time she administered medications.	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 364	Continued From page 55 -The first she knew of late medications or FSBSs was when she was informed by a resident a few weeks ago that her evening dose of insulin was being administered late in the evening. Refer to interview with the RCC on 10/19/23 at 10:22am. Refer to interview with a medication aide (MA) on 10/20/23 at 2:30pm. Refer to interview with the Administrator on 09/20/23 at 10:23am. _____ Interview with the RCC on 10/19/23 at 10:22am revealed: -Resident #5 called a couple of nights ago around 10:00pm-10:30pm and said she was not administered her nightly medications or insulin. -Resident #5 said she knocked on the MA's door and the MA would not answer. -She telephoned the MA and the MA reported she was about to administer the night medications but did not say why she had not administered them to the residents yet. -She did not know why all of the residents night medications had not been administered. Interview with a medication aide (MA) on 10/20/23 at 2:30pm revealed: -She administered insulin to the residents requiring insulin at meal times which was around 8:30am-9:00am, 12:30pm-1:00pm, and 5:30pm-6:00pm. -The bedtime dosages of insulin were administered between 10:00pm-10:30pm. -She knew the bedtime dosages were scheduled at either 8:00pm or 9:00pm. -She only gave the bedtime dosages of insulin to	D 364		

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the residents late once around 11:00pm a few nights ago because she was sick.
-She always administered the residents scheduled or sliding scale insulin (SSI) at the same time when she checked the fingerstick blood sugars (FSBS).
-She did not know a time was recorded in the glucometer when the FSBS was checked.
-She did not know why the FSBS reading times were recorded in the glucometers so late for meals and bedtime.

Interview with the Administrator on 10/20/23 at 10:23am revealed:
-She was not aware Resident #4 was not getting his insulin administered within the required timeframe.
-She was not aware Resident #5 was not getting his insulin administered within the required timeframe.
-She was unaware the residents received their insulin so late at night and it was unacceptable.
-Medications should be given within one hour before or after the prescribed time.

_____

The facility failed to administer Resident #4's sliding scale insulin (SSI) within one hour before or after the prescribed time causing treatment to be required at the local ED for low blood sugar levels and failed to administer Resident #5's lantus within one hour before or after the prescribed time. This failure placed the residents at substantial risk of serious physical harm and constitutes a Type A2 Violation.

_____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/18/23 for this violation.

THE CORRECTION DATE FOR THE TYPE A2

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D 364	Continued From page 57 VIOLATION SHALL NOT EXCEED NOVEMBER 19, 2023.	D 364		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Type B Violation Based on observations, record reviews, and interviews, the facility failed to ensure the accuracy of the medication administration records for 5 of 5 sampled residents (Resident #1, #2, #3, #4, #5). The findings are:	D 367		

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D 367	Continued From page 58 1. Review of Resident #4's current FL2 dated 09/20/23 revealed diagnoses included diabetes, hypertension, bladder dysfunction, gastroparesis (affects stomach muscles from emptying), gastric reflux and bipolar disorder. a. Review of Resident #4's physician's orders dated 08/31/23 revealed: -There was a medication order for amlodipine (used to treat hypertension) 10mg take 1 tablet daily. -There was a medication order for lisinopril (used to treat hypertension) 40mg take 1 tablet daily. -There was a medication order for magnesium oxide (to treat low magnesium levels) 400mg take 1 tablet daily. -There was a medication order for metoprolol ER, [Extended Release; used to treat hypertension] 50mg take 1 tablet daily. -There was a medication order for myrbetriq (treats overactive bladder) 50mg tablet daily. -There was a medication order for Vitamin D3 1000 units (supplement) 2 tablets daily. -There was a medication order for bupropion 100mg (used to treat depression) 1 tablet twice daily. -There was a medication order for Eliquis 2.5mg (used to prevent blood clots) 1 tablet twice daily. -There was a medication order for advair 250-50 inhale 1 puff twice daily. -There was a medication order for Omeprazole 20mg (used to treat stomach acid) 1 capsule twice daily. -There was a medication order for Miralax powder (used to treat constipation) mix 1 capful in 8oz of beverage of choice twice daily. -There was a medication order for Preservision age-related eye disease study (AREDS) (a	D 367		

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supplement) 1 capsule twice daily.
-There was a medication order for Senokot (constipation) 2 tablets twice daily.
-There was a medication order for gabapentin (used to treat seizures) 100mg 1 capsule three times daily.
-There was a medication order for lithium ER [extended release, used to treat mood stability] 450mg 1 tablet daily.
-There was a medication order for Crestor (used to treat cholesterol) 20mg 1/2 tablet at bedtime.
-There was a medication order for sucralfate 1GM (used to treat stomach acid) 1 tablet four time daily before meals and at bedtime.
-There was a medication order for Flomax 0.4mg (used to treat urinary incontinence) 1 capsule at bedtime.
-There was a medication order for refresh Liquigel 1% (used to treat dry eyes) 1 drop in each eye five times daily while awake.
-There was a medication order for Novolog 6 units subcutaneous (SQ) (to treat blood sugar) before meals and bedtime.
-There was an order for sliding scale as follows; finger stick blood sugar (FSBS) of 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, over 400 give 0 units and call the physician for instructions.
-There was a medication order for Lantus 15 units SQ (to treat blood sugar) twice daily.
-There was a medication order for remedy clear aid ointment apply to bilateral foot twice daily.

Review of Resident #4's September 2023 medication administration record revealed:
-There were 30 days in September 2023.
-There was an an entry for amlodipine 10mg take 1 tablet with documentation of administration on 09/31/23 at 9:00am daily.
-There was an entry for lisinopril 40mg take 1

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tablet daily with documentation of administration on 09/31/23 at 9:00am daily.
-There was an entry for magnesium oxide 400mg take 1 tablet daily with documentation of administration on 09/31/23 at 9:00am.
-There was an entry for methanamine hippurate 1GM one tablet daily with documentation of administration on 09/31/23 at 9:00am.
-There was an entry for methimazde 5mg one tablet daily with documentation of administration on 09/31/23 at 9:00am.
-There was an entry for metoprolol Extended Release (ER) 50mg take 1 tablet daily with documentation of administration on 09/31/23 at 9:00am.
-There was an entry for myrbetriq 50mg tablets tablet daily with documentation of administration on 09/31/23 at 9:00am.
-There was an order for melatonin 3mg one tablet at bedtime with documentation of administration on 09/31/23 at 9:00pm.
-There was an entry for Vitamin D3 1000 units 2 tablets daily with documentation of administration on 09/31/23 at 9:00am.
-There was an entry for bupropion 100mg 1 tablet twice daily with documentation of administration on 09/31/23 at 9:00am.
-There was an entry for Eliquis 2.5mg 1 tablet twice daily with documentation of administration on 09/31/23 at 9:00am and 9:00pm.
-There was an entry for advair 250-50 inhale 1 puff twice daily with documentation of administration on 09/31/23 at 9:00am.
-There was an entry for omeprazole 20mg 1 capsule twice daily with documentation of administration on 09/31/23 at 9:00am, 6:00pm.
-There was an entry for Miralax powder mix 1 capful in 8oz. of beverage of choice twice daily with documentation of administration on 09/31/23 at 9:00am.

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D 367	Continued From page 61 -There was an entry for multivitamin 1 capsule daily with documentation of administration on 09/31/23 at 9:00am and 9:00pm. -There was an entry for ropinirole HCL 3mg one tablet at bedtime with documentation of administration on 09/31/23 at 9:00pm. -There was an entry for Senokot 2 tablets twice daily with documentation of administration on 09/31/23 at 9:00pm. -There was an entry for gabapentin 100mg 1 capsule three times daily with documentation of administration on 09/31/23 at 9:00am, 12:00pm and 9:00pm. -There was an entry for lithium ER 450mg 1 tablet daily with documentation of administration on 09/31/23 at 9:00pm. -There was an entry for Crestor 20mg 1/2 tablet at bedtime with documentation of administration on 09/31/23 at 9:00pm.. -There was an entry for sucralfate 1GM 1 tablet four time daily before meals and at bedtime with documentation of administration on 09/31/23 at 9:00am, 1:00pm, 6:00pm and 8:00pm. -There was an entry for Flomax 0.4mg 1 capsule at bedtime with documentation of administration on 09/31/23 at 9:00am. -There was an entry for refresh Liquigel 1% one drop in each eye five times daily while awake with documentation of administration on 09/31/23 at 9:00am, 12:00pm, 6:00pm, 9:00pm and 12:00pm. -There was an entry for Novolog 6 units subcutaneous (SQ) before meals and bedtime with documentation of administration on 09/31/23 at 9:00am. -There was an entry for Lantus 15 units SQ twice daily with documentation of administration on 09/31/23 at 9:00am. -There was an entry for Lidocaine 5% patch apply every 12 hours then remove with documentation of administration on 09/31/23 with no time of	D 367		

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administration.
-There was an entry for potassium chloride 20meq one tablet daily with documentation of administration on 09/31/23 at 9:00am.
-There was an entry for furosemide 20mg one tablet daily with documentation of administration on 09/31/23 at 9:00am.

Refer to the interview with the medication aide (MA) on 10/19/23 at 4:20pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 10/20/23 at 10:55am.

Refer to the interview with the Administrator on 10/20/23 at 2:55pm.

Attempted telephone interview with the local veterans administration medical center (VAMC) hospital pharmacy on 10/17/23 at 12:14pm, 10/19/23 at 11:10am and 12:30pm was unsuccessful.

b. Review of Resident #4's physician's orders dated 08/31/23 revealed an order for sucralfate (used to treat stomach acid) 1GM one tablet four time daily before meals and at bedtime.
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Review of Resident #4's physician's orders dated 08/21/23 revealed an order for gabapentin (used to treat seizures)100mg one capsule three times daily.

Review of Resident #4's August 2023 medication administration record (MAR) revealed:
-There was an entry for sucralfate 1GM one tablet four time daily before meals and at bedtime.
-There was documentation sucralfate 1GM was administered daily at 9:00am, 1:00pm, 6:00pm

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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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and 8:00pm from 08/01/23-08/31/23.
-There was an entry for gabapentin 100mg 1 capsule three times daily.
-There was documentation gabapentin 100mg was administered daily at 9:00am, 12:00pm and 9:00pm from 08/01/23-08/31/23.

Review of Resident #4's September 2023 MAR revealed:
-There was an entry for sucralfate 1GM one tablet four times daily before meals and at bedtime.
-There was documentation sucralfate 1GM was administered daily at 9:00am, 1:00pm, 6:00pm and 8:00pm from 09/01/23-09/31/23.
-There was an entry for gabapentin 100mg one capsule three times daily.
-There was documentation gabapentin 100mg was administered daily at 9:00am, 12:00pm and 9:00pm from 09/01/23-09/31/23.

Review of Resident #4's October 2023 MAR revealed:
-There was an entry for sucralfate 1GM one tablet four times daily before meals and at bedtime.
-There was documentation sucralfate 1GM was administered daily at 9:00am, 1:00pm, 6:00pm and 8:00pm from 10/01/23-10/08/23.
-There was an entry for gabapentin 100mg one capsule three times daily.
-There was documentation gabapentin 100mg was administered daily at 9:00am, 12:00pm and 9:00pm from 10/01/23-10/31/23.

Observation of Resident #4's medications available for administration on 10/18/23 at 10:05am revealed gabapentin and carafate were not available for administration.

Interview with a MA on 10/18/23 at 10:15am revealed:

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-Resident #4 ran out of gabapentin and carafate two or three days ago.
-When she needed to document on the MAR that she did not administer a medication she wrote her initials and then put a line through it and wrote a note on the back of the MAR to explain why the medication was not administered.

Telephone interview with the facility's contracted registered nurse (RN) on 10/19/23 at 3:37pm revealed the facility was responsible for making sure all medications ordered for residents were available to administer and the MAs were taught to accurately document on the MAR when she reeducated the MA and MA/RCC in May 2023.

Refer to the interview with the medication aide (MA) on 10/19/23 at 4:20pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 10/20/23 at 10:55am.

Refer to the interview with the Administrator on 10/20/23 at 2:55pm.

Attempted telephone interview with the local VAMC hospital pharmacy on 10/17/23 at 12:14pm, 10/19/23 at 11:10am and 12:30pm at was unsuccessful.

2. Review of Resident #1's current FL2 dated 04/20/23 revealed:
-Diagnoses that included neuroleptic induced Parkinson's disease, dysphagia, bipolar disorder and hemiparesis.

Review of Resident #1's physician's orders dated 04/01/23 revealed:
-There was a medication order for aspirin 81mg (used for circulation) one tablet daily.

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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 367	Continued From page 65 -There was a medication order for folic acid 1 mg (a supplement) one tablet daily. -There was a medication order for magnesium oxide 400mg (a supplement) one tablet daily. -There was a medication order for meloxicam 15mg (used to treat arthritis) one tablet daily. -There was a medication order for omeprazole 40mg (used to trea stomach acid) one capsule daily. -There was a medication order for pepcid 20mg (used to treat ulcers) one tablet twice daily. -There was a medication order for metoprolol 25mg (used to treat blood pressure) 1/2 tablet twice daily. -There was a medication order for clozapine 100mg (used to treat severe schizophrenia) one tablet at bedtime. -There was a medication order for pravastatin 80mg (used to treat high cholesterol) 1/2 tablet at bedtime. -There was a medication order for flomax 0.4mg (used to treat enlarged prostate) one capsule at bedtime. -There was a medication order for atropine 1% (used to decrease saliva) 1 drop under the tongue on each side at bedtime. -There was a medication order for trazodone 100mg (used for sleep) two tablets at bedtime. -There was a medication order for flexeril 10mg (used for muscle pain) one tablet twice daily as needed. Review of Resident #1's September 2023 medication administration record revealed: -There were 30 days in September 2023. -There was an entry for aspirin 81mg one tablet daily with documentation of administration on 09/31/23 at 9:00am. -There was an entry for folic acid 1mg one tablet daily with documentation of administration on	D 367		

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09/31/23 at 9:00am.
-There was an entry for magoxide 400mg one tablet daily with documentation of administration on 09/31/23 at 9:00am.
-There was an entry for meloxicam 15mg one tablet daily with documentation of administration on 09/31/23 at 9:00am.
-There was an entry for omeprazole 40mg one capsule daily with documentation of administration on 09/31/23 at 9:00am.
-There was an entry for pepcid 20mg one tablet twice daily with documentation of administration on 09/31/23 at 9:00am and 9:00pm.
-There was an entry for metoprolol 25mg 1/2 tablet twice daily with documentation of administration on 09/31/23 at 9:00am and 9:00pm.
-There was an entry for clozapine 100mg one tablet at bedtime with documentation of administration on 09/31/23 at 9:00pm.
-There was an entry for pravastatin 80mg 1/2 tablet at bedtime with documentation of administration on 09/31/23 at 9:00pm.
-There was an entry for flomax 0.4mg one capsule at bedtime with documentation of administration on 09/31/23 at 9:00pm.
-There was an entry for trazodone 100mg two tablets at bedtime with documentation of administration on 09/31/23 at 8:00pm.
-There was an entry for flexeril 10mg one tablet twice daily as needed with documentation of administration on 09/31/23 at 9:00am.

Refer to the interview with the medication aide (MA) on 10/19/23 at 4:20pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 10/20/23 at 10:55am.

Refer to the interview with the Administrator on

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D 367	Continued From page 67 10/20/23 at 2:55pm. 3. Review of Resident #3's current FL2 dated 01/11/23 revealed diagnoses included diabetes mellitus type 2, history of urinary tract infections (UTIs), seizure disorder, sleep disorder, asthma, seasonal allergies, hypertension, coronary artery disease, hyperlipidemia, depression, schizoaffective disorder bipolar type, acute delirium, borderline intellectual functioning, early dementia, osteoarthritis, obstructive sleep apnea, and gastroesophageal reflux disease (GERD). a. Review of Resident #3's physician's orders dated 01/11/23 revealed: -There was a medication order for amlodipine (used to treat hypertension) 10mg take 1 tablet daily. -There was a medication order for aspirin (used as a blood thinner) 81mg take 1 tablet daily. -There was a medication order for lisinopril (used to treat hypertension) 40mg take 1 tablet daily. -There was a medication order for magnesium oxide (used to treat low magnesium levels) 400mg take 1 tablet daily. -There was a medication order for metoprolol ER [extended release; (used to treat hypertension)] 50mg take 1 tablet daily. -There was a medication order for sertraline (used to treat depression) 25mg take 1 tablet daily. -There was a medication order for venlafaxine ER [extended release;](used to treat depression)] 75mg take 1 capsule daily. -There was a medication order for vitamin D3 (used to treat low vitamin D levels) 1000u take 1 capsule daily. -There was a medication order for docusate (used to treat constipation) 100mg take 1 capsule	D 367		

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twice daily for constipation.
-There was a medication order for fluticasone (used to treat seasonal allergies) 50mcg place 1 spray into each nostril twice daily.
-There was a medication order for lansoprazole [used to treat high acid levels associated with gastroesophageal reflux disease (GERD)] 30mg take 1 capsule twice daily.
-There was a medication order for Keppra (used to treat seizures) 750mg take 1 tablet twice daily.
-There was a medication order for meloxicam (used to treat osteoarthritis) 7.5mg take 1 tablet twice daily.
-There was a medication order for metformin ER [extended release; (used to treat diabetes)] 500mg take 1 tablet twice daily.
-There was a medication order for risperidone (used to treat schizophrenia and bipolar disorder) 1mg take 1 tablet twice daily.
-There was a medication order for saline nasal spray (used to flush out congested nasal passages associated with seasonal allergies) 0.65% place 1 spray in each nostril twice daily.
-There was a medication order for Humalog (a fast-acting insulin used to treat diabetes) inject 3 units three times daily.
-There was a medication order for cetirizine (used to treat seasonal allergies) 10mg take 1 tablet at bedtime.
-There was a medication order for olanzapine (used to treat schizophrenia and bipolar disorder) 10mg take 1 tablet at bedtime.
-There was a medication order for simvastatin (used to treat high cholesterol and triglyceride levels) 10mg take 1 tablet at bedtime.
-There was a medication order for Trulicity (used to treat diabetes) 3mg/0.5ml inject 0.5ml every Wednesday.

Review of Resident #3's September 2023

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medication administration record revealed:
-There were 30 days in September 2023.
-There was an entry for amlodipine 10mg take 1 tablet daily with documentation of administration on 09/31/23 at 9:00am.
-There was an entry for aspirin 81mg take 1 tablet daily with documentation of administration on 09/31/23 at 9:00am.
-There was an entry for lisinopril 40mg take 1 tablet daily with documentation of administration on 09/31/23 at 9:00am.
-There was an entry for magnesium oxide 400mg take 1 tablet daily with documentation of administration on 09/31/23 at 9:00am.
-There was an entry for metoprolol ER 50mg take 1 tablet daily with documentation of administration on 09/31/23 at 9:00am.
-There was an entry for sertraline 25mg take 1 tablet daily with documentation of administration on 09/31/23 at 9:00am.
-There was an entry for venlafaxine ER 75mg take 1 tablet daily with documentation of administration on 09/31/23 at 9:00am.
-There was an entry for vitamin D3 1000u take 1 capsule daily with documentation of administration on 09/31/23 at 9:00am.
-There was an entry for docusate 100mg take 1 capsule twice daily with documentation of administration on 09/31/23 at 9:00am and 9:00pm.
-There was an entry for fluticasone 50mcg nasal spray place 1 spray into each nostril twice daily with documentation of administration on 09/31/23 at 9:00am and 9:00pm.
-There was an entry for lansoprazole 30mg take 1 capsule twice daily with documentation of administration on 09/31/23 at 9:00am and 9:00pm.
-There was an entry for Keppra 750mg take 1 tablet twice daily with documentation of

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administration on 09/31/23 at 9:00am and 9:00pm.
-There was an entry for meloxicam 7.5mg take 1 tablet twice daily with documentation of administration on 09/31/23 at 9:00am and 9:00pm.
-There was an entry for metformin ER 500mg take 1 tablet twice daily with documentation of administration on 09/31/23 at 9:00am and 9:00pm.
-There was an entry for risperidone 1mg take 1 tablet twice daily with documentation of administration on 09/31/23 at 9:00am and 9:00pm.
-There was an entry for saline nasal spray 0.65% use 1 spray in each nostril twice daily with documentation of administration on 09/31/23 at 9:00am and 9:00pm.
-There was an entry for Humalog 100u/ml inject 3 units three times daily with documentation of administration on 09/31/23 at 9:00am, 2:00pm, and 9:00pm.
-There was an entry for cetirizine 10mg take 1 tablet at bedtime with documentation of administration on 09/31/23 at 8:00pm.
-There was an entry for olanzapine 10mg take 1 tablet at bedtime with documentation of administration on 09/31/23 at 8:00pm.
-There was an entry for simvastatin 10mg take 1 tablet at bedtime with documentation of administration on 09/31/23 at 8:00pm.
-There was an entry for Trulicity 3mg/0.5ml inject 0.5ml every Wednesday with documentation of administration on 09/31/23 at 8:00am.

Refer to the interview with the medication aide (MA) on 10/19/23 at 4:20pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 10/20/23 at 10:55am.

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D 367	Continued From page 71 Refer to the interview with the Administrator on 10/20/23 at 2:55pm. b. Review of Resident #3's physician's orders dated 07/18/23 revealed an order for a cranberry supplement (used to prevent urinary tract infections) take 1 tablet daily. Review of Resident #3's physician's orders dated 09/05/23 revealed an order for a cranberry supplement take 1 tablet daily. Review of Resident #3's August 2023 medication administration record (MAR) revealed: -There was an entry for cranberry supplement take 1 tablet daily. -There was documentation a cranberry tablet was administered daily at 9:00am from 08/01/23-08/31/23. Review of Resident #3's September 2023 MAR revealed: -There was an entry for cranberry supplement take 1 tablet daily. -There was documentation a cranberry tablet was administered daily at 9:00am from 09/01/23-09/31/23 (there were 30 days in September 2023). Review of Resident #3's October 2023 MAR revealed: -There was an entry for cranberry supplement take 1 tablet daily. -There was documentation a cranberry tablet was administered daily at 9:00am from 10/01/23-10/08/23. Observation of medications on hand on 10/18/23 at 11:27am revealed there was no cranberry	D 367		

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supplement available for administration.

Interview with a medication aide (MA) on 10/18/23 at 11:38am revealed she did not know why Resident #3's cranberry supplement was not available to administer or when the medication ran out.

Telephone interview with a pharmacy technician for the facility's contracted pharmacy on 10/18/23 at 3:25pm revealed:
-Resident #3's cranberry supplement was last dispensed on 05/16/23 in the quantity of 30 tablets and would last 30 days if administered as written.
-The pharmacy had not received a refill request for Resident #3's cranberry supplement since it was last dispensed on 05/16/23.

Interview with the Resident Care Coordinator (RCC) on 10/18/23 at 4:28pm revealed:
-She thought Resident #3 had cranberry available or she would not have documented that she administered it.
-She always signed the MAR at the same time she administered medications.

Second interview with a MA on 10/19/23 at 9:13am revealed:
-She remembered administering Resident #3's cranberry tablet daily during the month of August 2023, September 2023, and 10/01/23-10/08/23.
-She did not know how Resident #3's cranberry supplement was available to administer when it should have run out in June 2023 if the cranberry supplement was administered as ordered.
-She knew she was supposed to document a medication on the MAR as not administered if the medication was not available.
-She signed her initials on the MAR and would

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draw a line through her initials if the medication was not administered.

Telephone interview with the facility's contracted registered nurse (RN) on 10/19/23 at 3:37pm revealed:
-She completed MAR audits randomly by rotating the residents or when the facility requested a cart/MAR audit.
-The last thorough MAR audits were completed in May 2023.
-She compared the MARs to the medications available on the cart.
-She did not know the date for the last MAR audit completed for Resident #3.
-The MAs were taught to accurately document on the MAR when she reeducated the MA and MA/RCC in May 2023.

Interview with the Administrator on 10/20/23 at 2:55 pm revealed:
-She did not know why the MAs documented on the MAR administering Resident #3's cranberry supplement from 08/01/23-10/08/23 when the cranberry was unavailable.
-The facility's contracted RN visited the facility every 2 weeks, and she thought the nurse completed MAR audits every time to make sure all the resident's MARs were accurate.
-She expected the MAs to accurately document on the MARs if a medication was administered or not administered if the medication was not available.

c. Review of Resident #3's hospital discharge medication orders dated 05/31/23 revealed an order change for melatonin (used to promote sleep) 3mg take 2 tablets at bedtime.

Review of Resident #3's physician's order dated

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D 367	Continued From page 74 09/05/23 revealed an order for melatonin 3mg take 2 tablets at bedtime. Review of Resident #3's August 2023 medication administration record (MAR) revealed: -There was an entry for melatonin 3mg take 2 tablets at bedtime. -There was documentation melatonin was administered daily at 9:00pm from 08/01/23-08/31/23. Review of Resident #3's September 2023 MAR revealed: -There was an entry for melatonin 3mg take 2 tablets at bedtime. -There was documentation melatonin was administered daily at 9:00pm from 09/01/23-09/31/23 (there were 30 days in September 2023). Review of Resident #3's October 2023 MAR revealed: -There was an entry for melatonin 3mg take 2 tablets at bedtime. -There was documentation melatonin was administered daily at 9:00pm from 10/01/23-10/07/23. Observation of medications on hand on 10/18/23 at 11:27am revealed there was no melatonin available for administration. Interview with the Resident Care Coordinator (RCC)/MA on 10/18/23 at 4:28pm revealed: -She always signed the MAR at the same time she administered medications. -She did not know why the MA documented the melatonin as administered on 09/31/23 when there were 30 days in September 2023.	D 367		

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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 367	Continued From page 75 Interview with a MA on 10/19/23 at 9:13am revealed: -She did not remember if she administered Resident #3's melatonin during the month of August 2023, September 2023, and 10/01/23-10/07/23. -She thought she administered melatonin nightly at bedtime because she documented that she administered the melatonin. -She documented the administration of Resident #3's medications including the melatonin on 09/31/23 on the MAR by accident. -She knew she was supposed to document a medication on the MAR as not administered if the medication was not available. -She signed her initials on the MAR and would draw a line through her initials if the medication was not administered. Telephone interview with the facility's contracted RN on 10/19/23 at 3:37pm revealed: -She completed MAR audits randomly by rotating the residents or when the facility requested a MAR audit. -The last thorough MAR audit was completed in May 2023. -She compared the MARs to the medications available on the cart. -She did not know the date for the last MAR audit completed for Resident #3. -The MAs were taught to accurately document on the MAR when she reeducated the MA and MA/RCC in May 2023. Interview with the Administrator on 10/20/23 at 2:55 pm revealed: -The facility's contracted RN visited the facility every 2 weeks, and she thought the RN completed MAR audits every time to make sure all the resident's MARs were accurate.	D 367		

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D 367	Continued From page 76 -She expected the MAs to accurately document on the MARs if a medication was administered or not administered if the medication was unavailable. 4. Review of Resident #5's current FL2 dated 05/04/23 revealed diagnoses included major depressive disorder, diabetes, hypertension and gastro-esophageal reflux disease (GERD). a. Review of Resident #5's phycician orders revealed an order dated 07/28/23 for Trulicity 3mg/0.5ml inject 0.5ml weekly (used to treat diabetes). Review of Resident #5's September 2023 medication administration record (MAR) revealed: -There was an entry for Trulicity 3mg/0.5ml inject 0.5ml weekly. -There was documentation Trulicity 3mg/0.5ml inject 0.5ml weekly was administered on Tuesday 09/05/23, Tuesday 09/12/23, Tuesday 09/19/23, Tuesday 09/26/23 and 09/31/23 (date does not exist). Review of the September 2023 Finger stick blood sugar (FSBS)/insulin administration log attached to Resident #5's September 2023 MAR revealed: -There was documentation at the top of the log for Trulicity 3mg/0.5ml inject 0.5ml weekly on Thursdays. -There was documentation Trulicity 3mg/0.5ml inject 0.5ml weekly was administered on Thursday 09/07/23, Thursday 09/14/23 and Thursday 09/21/23. -There was no documentation Resident #5 received a fourth dose of Trulicity in September 2023.	D 367		

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D 367	Continued From page 77 Review of Resident #5's October 2023 medication administration record (MAR) revealed: -There was an entry for Trulicity 3mg/0.5ml inject 0.5ml weekly. -There was documentation Trulicity 3mg/0.5ml inject 0.5ml weekly was administered on Tuesday 10/03/23, Tuesday 10/10/23 and Tuesday 10/17/23. Review of the October 2023 Finger stick blood sugar (FSBS)/insulin administration log attached to the October 2023 MAR revealed: -There was documentation at the top of the log for Trulicity 3mg/0.5ml inject 0.5ml weekly on Thursdays. -There was documentation Trulicity 3mg/0.5ml inject 0.5ml weekly was administered on Thursday 10/05/23 and Thursday 10/12/23. Interview with the medication aide (MA) on 10/19/23 at 4:20pm revealed: -She documented all the medications administered after she completed the entire medication pass as she was taught by the Resident Care Coordinator (RCC) instead of documenting after she administered the medications to each resident. -She did not know if the facility had a policy on medication administration and documenting the administration of medications on the medication administration record (MAR). Interview with the RCC on 10/18/23 at 4:28pm revealed: -She always signed the MAR at the same time she administered medications. -They stopped using the MAR and started using new FSBS monitoing logs in September.	D 367		

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Telephone interview with the facility's contracted RN on 10/19/23 at 3:37pm revealed:
-She completed MAR audits randomly by rotating the residents or when the facility requested a MAR audit.
-The last thorough MAR audit was completed in May 2023.
-She taught how to accurately document on the MAR when she reeducated the MA and MA/RCC in May 2023.

Interview with the Administrator on 10/17/23 at 10:22am and 10/20/23 at 2:55pm revealed:
-The MAs documented FSBS and the amount of insulin administered on the MAR in September 2023 but they had a difficult time writing the FSBS values in the box provided on the MAR, so she made up a FSBS and insulin log for the MAs to document on instead beginning September 2023.
-She implemented using the FSBS and insulin log to keep all the insulin and FSBS documented for a resident on one piece of paper.
-The facility's contracted RN visited the facility every 2 weeks and completed a MAR audit to make sure Resident #5's insulin was being administered correctly.
-The facility's contracted RN visited the facility every 2 weeks, and she thought the nurse completed MAR audits every time to make sure all the resident's medications were administered as ordered.
-She expected the MAs to accurately document on the MARs.

b. Review of Resident #5's physician's orders revealed:
- There was an order dated 05/04/23 for cetirizine 10mg daily (used to treat allergies).
- There was an order dated 05/04/23 for folic acid 1mg daily (used for vitamin supplementation).

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D 367	Continued From page 79 - There was an order dated 05/04/23 for mag ox 400mg daily (used to treat magnesium deficiency). - There was an order dated 08/14/23 for sertraline 100mg daily (used to treat depression). - There was an order dated 05/04/23 for therems 1 tablet daily (a vitamin supplement). - There was an order dated 06/20/23 for diclofenac 1% gel, apply 2gm to leg four times daily (used to treat pain). - There was an order dated 05/04/23 for gabapentin 600mg at bedtime (used to treat nerve pain). - There was an order dated 05/04/23 for levothyroxine 137mcg at bedtime (used to treat hypothyroisidm) - There was an order dated 06/06/23 for lisinopril 20mg at bedtime (used to treat blood pressure). - There was an order dated 05/04/23 for mirtazapine 15mg at bedtime (used to treat depression). - There was an order dated 05/04/23 for pantroprazole 40mg at bedtime (used to treat reflux). - There was an order dated 05/04/23 for pramipexole 1.5mg at bedtime (used to treat depression). - There was an order dated 05/04/23 for pravastatin 40mg at bedtime (used to treat cholesterol). - There was an order dated 07/31/23 for blood pressure readings daily - There was an order dated 06/20/23 for lantus, inject 22 units twice daily (used to treat diabetes). Review of Resident #5's September 2023 MAR revealed: -There were 30 days in September 2023. -There was an entry for cetirizine 10mg daily with documentation it was administered on 09/31/23.	D 367		

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D 367	Continued From page 80 -There was an entry for folic acid 1mg daily with documentation it was administered on 09/31/23. -There was an entry for mag-ox 400mg daily with documentation it was administered on 09/31/23. -There was an entry for 08/14/23 for sertraline 100mg daily with documentation it was administered on 09/31/23. -There was an entry for therems 1 tablet daily with documentation it was administered on 09/31/23. -There was an entry for diclofenac 1% gel, apply 2gm to leg four times daily with documentation it was administered four times on 09/31/23. -There was an entry for gabapentin 600mg at bedtime with documentation it was administered on 09/31/23. -There was an entry for levothyroxine 137mcg at bedtime with documentation it was administered on 09/31/23. -There was an entry for lisinopril 20mg at bedtime with documentation it was administered on 09/31/23. -There was an entry for mirtazapine 15mg at bedtime with documentation it was administered on 09/31/23. -There was an entry for pantroprazole 40mg at bedtime with documentation it was administered on 09/31/23. -There was an entry for pramipexole 1.5mg at bedtime with documentation it was administered on 09/31/23. -There was an entry for pravastatin 40mg at bedtime with documentation it was administered on 09/31/23. -There was an entry for a blood pressure reading daily with documentation it was administered on 09/31/23. -There was an entry for lantus, inject 22 units twice daily with documentation it was administered twice on 09/31/23.	D 367		

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D 367	Continued From page 81 Refer to the interview with the medication aide (MA) on 10/19/23 at 4:20pm. Refer to the interview with the Resident Care Coordinator (RCC) on 10/20/23 at 10:55am. Refer to the interview with the Administrator on 10/20/23 at 2:55pm. 5. Review of Resident #2's current FL2 dated 05/09/23 revealed diagnoses included dementia, hypertension, diabetes and chronic kidnes disease. Review of Resident #2's physician's orders revealed: -There was an order dated 06/09/23 for citalopram 20mg daily (used to treat mood disorder). -There was an order dated 06/09/23 for clopidogrel 75mg daily (used to treat heart disease). -There was an order dated 06/09/23 for finasteride 5mg daily (used to treat urinary retention). -There was an order dated 08/08/23 for lisinopril 2.5mg daily (used to treat blood pressure and kidney disease). -There was an order dated 06/09/23 for Preservision AREDS twice a day (used for eye health). -There was an order dated 06/09/23 for simvastatin 40mg daily (used to treat elevated cholesterol). -There was an order dated 06/09/23 for tamsulosin 0.4mg at bedtime (used to treat urinary retention). -There was an order dated 07/03/23 for trazodone 50mg 1/2 tablet at bedtime (used to	D 367		

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treat sleep disorder).
-There was an order dated 07/13/23 for miconazole powder to groin twice daily (used to treat rashes).
-There was an order dated 07/13/23 for zinc cream to buttocks twice daily (used for skin protection).
-There was an order dated 07/06/23 for folic acid 1mg daily (a vitamin supplement).
-There was an order dated 05/09/23 for Vitamin D3 25mg daily (a vitamin supplement).
-There was an order dated 09/25/23 for doxycycline hyclate 100mg twice daily for 5 days (used to treat infection).

Review of Resident #2's September 2023 MAR revealed:
-There were 30 days in September 2023.
-There was an entry for citalopram 20mg daily.
-There was documentation citalopram was administered on 09/31/23.
-There was an entry for clopidogrel 75mg daily.
-There was documentation clopidogrel was administered on 09/31/23.
-There was an entry for finasteride 5mg daily.
-There was documentation finasteride was administered on 09/31/23.
-There was an entry for lisinopril 2.5mg daily.
-There was documentation lisinopril was administered on 09/31/23.
-There was an entry for Preservision AREDS twice a day.
-There was documentation preservision areds was administered twice on 09/31/23.
-There was an entry for simvastatin 40mg daily.
-There was documentation simvastatin was administered on 09/31/23.
-There was an entry for tamsulosin 0.4mg at bedtime.
-There was documentation tamsulosin was

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administered on 09/31/23.
-There was an entry for trazodone 50mg, 1/2 tablet at bedtime.
-There was documentation trazodone was administered on 09/31/23.
-There was an entry for miconazole powder to groin twice daily.
-There was documentation miconazole powder was administered twice on 09/31/23.
-There was an entry for zinc cream to buttocks twice daily.
-There was documentation zinc cream was administered twice on 09/31/23.
-There was an entry for folic acid 1mg daily.
-There was documentation folic acid was administered on 09/31/23.
-There was an entry for Vitamin D3 25mg daily.
-There was documentation Vitamin D3 was administered on 09/31/23.
-There was an entry for doxycycline hyclate 100mg twice daily for 5 days.
-There was documentation doxycycline hyclate was administered twice on 09/31/23.

Refer to the interview with the medication aide (MA) on 10/19/23 at 4:20pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 10/20/23 at 10:55am.

Refer to the interview with the Administrator on 10/20/23 at 2:55pm.

_____

Interview with the medication aide (MA) on 10/19/23 at 4:20pm revealed:
-She did not know why she documented she administered all the resident's medications on 09/31/23 when there were only 30 days in September 2023.
-She documented all the medications

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administered after she completed the entire medication pass as she was taught by the Resident Care Coordinator (RCC) instead of documenting after she administered the medications to each resident.
-She did not know if the facility had a policy on medication administration and documenting the administration of medications on the medication administration record (MAR).

Interview with the RCC on 10/20/23 at 10:55am revealed:
-She knew medications were supposed to be documented when they were administered to each resident, but she would sometimes document all the medications administered to all the residents after she had completed the entire medication pass when she was in a "hurry".
-She taught the MA how to document on the MARs.
-She did not know that she was supposed to document the administration of medications after each resident before she administered medications to another resident.
-The MA should not have documented medications were administered to all the residents on 09/31/23 since there were only 30 calendar days in September 2023.

Interview with the Administrator on 10/20/23 at 2:55pm revealed:
-She did not know the MA documented all the resident's medications as administered on the MAR on 09/31/23.
-She did not know why the MA would have documented all the resident's medications as administered on 09/31/23 when there were only 30 days in September.
-She expected the MAs to document each resident's medications when they were

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D 367	Continued From page 85 administered before administering another resident's medications. -The facility's contracted RN completed MAR audits when she visited the facility every 2 weeks to check for MAR accuracy and did not find the error for the medications documented as administered on 09/31/23. _____ The facility failed to ensure documentation on the MAR of a rapid-acting sliding scale insulin for Resident #4 which placed the resident at increased risk for receiving too much insulin or not enough insulin that could lead to vision problems, decreased kidney function, infection with poor healing and numbness of the hands and feet. This failure was detrimental to the health and welfare of Resident #4 and constitutes a Type B Violation. _____ The facility failed to provide a plan of protection in accordance with G.S. 131D-34 by 10/19/23 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 04, 2023.	D 367		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary.	D 406		

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This Rule is not met as evidenced by:
Based on interviews and record review, the facility failed to follow up on a pharmacy review recommendation for 1 of 1 sampled resident (Resident #3).

The findings are:

Review of Resident #3's current FL2 dated 01/11/23 revealed diagnoses included depression, schizoaffective disorder bipolar type, acute delirium, early dementia, and borderline intellectual functioning.

Review of Resident #3's physician order dated 01/12/23 revealed there was a medication order for venlafaxine (used to treat depression) 75mg take 1 tablet daily.

Review of Resident #3's local hospital discharge physician's orders dated 05/30/23 revealed:
-There was a medication order for sertraline (used to treat depression) 25mg take 1 tablet daily.
- There was an order to discontinue venlafaxine 75mg take 1 tablet daily.

Review of Resident #3's physician's orders report dated 09/05/23 revealed:
-There was a medication order for venlafaxine 75mg take 1 tablet daily.
-There was a medication order for sertraline 25mg take 1 tablet daily.

Review of Resident #3's quarterly pharmacy recommendation dated 09/27/23 revealed there was a pharmacist recommendation to discontinue either sertraline or venlafaxine due to a potential increased risk of Resident #3 developing serotonin syndrome (a serious drug reaction

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caused by medications, usually combining medications that contain serotonin, that build up high levels of serotonin in the body causing signs and symptoms ranging from agitation, restlessness, confusion, rapid heart rate, high blood pressure, diarrhea, headache, fever, seizures, and/or death).

Review of Resident #3's chart notes revealed:
-There was no documentation that the primary care physician (PCP) was notified of the pharmacist recommendations dated 09/27/23.
-There was no additional documentation of attempts to notify Resident #3's PCP.

Review of Resident #3's local hospital discharge summary dated 10/12/23 at 6:51pm revealed:
-Resident #3 was admitted on 10/08/23 at 1:11pm and was awaiting discharge to be admitted to an inpatient psychiatry unit when a bed was available.
-Venlafaxine 75mg was discontinued and sertraline 25mg take 1 tablet daily was continued.
-Resident #3 had thoughts of suicidal ideation and homicidal ideation towards a staff member at the facility upon admission.
-Resident #3 discharge diagnoses included encephalopathy, urinary retention, bladder incontinence, diarrhea, and polypharmacy (the simultaneous use of multiple medications to treat conditions that increased the risk of an adverse event).

Interview with the Resident Care Coordinator (RCC)/MA on 10/18/23 at 10:30am revealed:
-She was responsible for faxing recommendations from the pharmacist to Resident #3's primary care provider (PCP).
-She did not know if she faxed Resident #3's pharmacist recommendation dated 09/27/23 to

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDWOOD ASSISTED LIVING	6 WINDWOOD DRIVE CANDLER, NC 28715

(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 406	Continued From page 88	D 406		

discontinue either sertraline or venlafaxine.
-If she faxed Resident #3's pharmacist recommendation to the PCP, she did not get a response from the provider, so she figured "it's a no go" and the PCP did not want to change Resident #3's medication orders.
-The fax machine did not provide a confirmation sheet when a document was faxed.
-She did not call to verify the fax was received or document that she faxed the recommendation.
-She had no system in place to make sure Resident #3's pharmacist recommendation was faxed or received by the PCP.

Telephone interview with Resident #3's PCP on 10/18/23 at 4:45pm revealed:
-The facility did not fax a pharmacy recommendation dated 09/27/23 for Resident #3 to discontinue either sertraline or venlafaxine.
-All faxes received at the office were scanned into a computer system and all telephone calls were documented.
-There was no documentation of any telephone calls made by the facility to the office regarding notifying her of the pharmacist recommendation for Resident #3 or that a fax was sent.
-It was important for the facility to follow up and notify her of any pharmacist recommendations so that she could make medication changes if needed.
-She could see in her computer system that Resident #3 was admitted to the local hospital but had limited access to the records.
-It was possible Resident #3 was experiencing serotonin syndrome due to being administered both venlafaxine and sertraline requiring hospitalization, but she could not say for sure due to the limited access to Resident #3's hospital record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011296	A. BUILDING: _____ B. WING _____	R 10/20/2023

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WINDWOOD ASSISTED LIVING	6 WINDWOOD DRIVE CANDLER, NC 28715

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D 406	Continued From page 89 Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/19/23 at 1:05pm revealed: -The medications venlafaxine and sertraline were not commonly prescribed together due to a risk of causing serotonin syndrome. -Another pharmacist at the pharmacy wrote the recommendation to the PCP to discontinue either venlafaxine or sertraline on 09/27/23. -The facility was responsible for sending the pharmacist recommendations to Resident #3's PCP. Interview with the Administrator on 10/20/23 at 2:55pm revealed: -She did not know the pharmacy recommendation dated 09/27/23 for Resident #3 was not faxed to the PCP. -The RCC was responsible for faxing pharmacist recommendations to the PCP. -The RCC was responsible to follow up and make sure a fax was received after it was sent because the fax machine did not provide confirmations. -She expected the RCC to fax all pharmacy recommendations to the PCP when received.	D 406		