Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Wilham Ridge
Address: 30 Dalea Drive Asheville, NC 28805
County: Buncombe
License Number: HAL011377

II. Date(s) of Visit(s): 05/28/2024
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 07/29/2024

Instructions to the Provider *(please read carefully)*:

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of the Corrective Action Plan. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 13F.1004(a) MEDICATION ADMINISTRATION Rule/Statutory Reference: An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. Level of Non-Compliance: Standard Deficiency Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as prescribed for 2 of 6 sampled residents (#1, #2) related to mental health (#1), pain management (#1) and medications used to control elevated blood glucose (#2). The findings are: 1.) a. Review of Resident #1's FL2 dated 04/18/24 revealed: -Diagnoses included multiple sclerosis, type 2 diabetes mellitus, hyperlipidemia, hypokalemia, chronic obstructive pulmonary disease, and gastroesophageal reflux disease. -The resident was semi-ambulatory and required assistance with bathing and dressing. Review of Resident #1's Resident Register dated 04/15/24 revealed: -Resident #1 was admitted to the facility on 04/15/24. -He had a suprapubic catheter (a hollow, flexible tube used to drain	☐ POC Accepted _____ *DSS Initials* Medication orders are to be verified, with the assistance of a pharmacist to ensure factors pertinent to safe and effective administration are adhered to. Further training on medication administration at the facility is conducted to increase team member competence and skills in administration.	08/18/24

urine from the bladder from a cut in the abdomen).
-He used a wheelchair.
-He required assistance with suprapubic catheter, bathing, ambulation, getting in/out of bed, skin care, and scheduling appointments.

Review of Resident #1's May 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Hydrocodone-acetaminophen 5-325mg - take 1 tablet by mouth every 6 hours as needed for pain.
-There was documentation this medication was not administered after the 05/27/24 at 5:21am dose.
-There was no documentation that the provider or pharmacy was notified the resident had run out of medications.

Interview with Resident #1 on 05/29/24 at 9:40am revealed:
-He was without his pain medication as they had run out.
-Medication was not available for "a day or two but I have MS, when I need pain medication, I really need it".
-He spoke with staff about medication and they just blamed one another.
-One staff told him it had not been ordered.
-Another staff reported the medication had been thrown away.
-Resident does not know what actually happened, but "it did not seem appropriate".
-He was told repeatedly that the facility forgot to order the medication beginning on 05/27.
-He did not know why the medication was a PRN as he took it multiple times per day.

Interview with a family member of Resident #1 on 05/28/24 at 3:30pn revealed:
-Resident #1 was in a lot of pain the previous night as the facility ran out of his PRN pain medication.
-He needed pain medication multiple times daily.
-She was unsure why the provider had not been asked for a routine order for pain medication due to her family members' high level of pain.

Interview with the pharmacist at the facility's contracted pharmacy on 06/25/24 at 3:00pm revealed:
-The facility received routine ordered medications on the same cycle each month.
-The medication pack cycle for this facility started on the 15th of each month for all pill form medications routinely ordered.
-It is is the responsibility of the facility to reorder PRN medications.
-The medication was not reordered.

Interview with a medication aid (MA) on 06/28/24 and 7/12/24 at 10:00am revealed:
- She knew Resident #1 ran out of his pain medication.
-The resident reported pain the day he was out of his medication.
-She did not ask specifics about the nature of the resident's pain.
-The resident's family member also reported he was in pain.

-She believed the Resident Care Coordinator (RCC) was aware the resident was in pain.

Interviews with the RCC on 05/28/24 at 4:00pm and 06/28/24 at 3:15pm revealed:
-Resident #1 reported pain frequently.
-She knew Resident #1 had run out of medication.
-She was responsible for reordering medications.
-She requested refills from the provider if needed.
-She was responsible for contacting the appropriate medical providers as needed.
-She had no record of provider notification.

Interview with the Administrator on 06/28/24 on 3:45pm revealed:
-He was unaware of issues with Resident #1's medications.
-The RCC was responsible for contacting the providers and reordering medications.

b. Review of Resident #1's May 2024 eMAR revealed:
-There was an entry for Buspirone HCL 30mg tablet - 1 tablet by mouth twice daily, used to treat anxiety.
-Staff documented that the medication was "on order from pharmacy" for those missed administrations - however medication was documented as administered on 05/22/24 at 6:00pm and 05/23/24 at 6:00pm.
-The resident was not administered this medication on 9 out of 21 administration opportunities.
-There was no documentation that the provider was notified of the missed doses.

Review of Resident #1's file on 07/12/24 revealed no care notes present.

Interview with Resident #1 on 05/29/24 at 9:40am revealed:
-He was concerned about his medication.
-He talked with staff about medication and that they just blamed one another.
-He does not know what happened but that it did not seem appropriate.

Interview with a MA on 06/28/24 and 7/12/24 at 10:00am revealed:
-She followed the medication orders in the eMAR.
-She was not aware of issues with medication passes.

Interview with the pharmacist at the facility's contracted pharmacy on 06/25/24 at 3:00pm revealed:
-The facility received routine ordered medications on the same cycle each month.
-The medication pack cycle for this facility started on the 15th of each month for all pill form medications routinely ordered.
-The facility should have had this medication available to administer to Resident #1.

Interviews with RCC on 05/28/24 at 4:00pm and 06/28/24 at 3:15pm

revealed:
-She believed this medication had been administered but had not been documented correctly.
-She had no documentation that it had been administered correctly.
-She was responsible for contacting the appropriate medical providers as needed.
-She would have contacted provider via telehealth if needed.
-There was no record of provider notification.

Interview with the Administrator on 06/28/24 at 3:45pm revealed:
-The facility had a new medication passing computer system.
-The staff were trained on the new system.
-The RCC was responsible for contacting providers.
-The RCC was responsible for re-ordering medications.

2.) Review of Resident #2's FL2 dated 04/18/24 revealed:
-Diagnoses included type 2 diabetes, anemia, COPD, and obesity.
-The resident was semi-ambulatory and required assistance with bathing and dressing.

Review of Resident #2's Resident Register dated 07/21/23 revealed:
-The resident required assistance with dressing, bathing, nail care, hair/skin care and scheduling appointments.
- She used both a walker and wheelchair PRN for ambulation.

a.)Review of Resident #2's May 2024 eMAR revealed:
-There was an entry for Insulin Lispro 100 unit/ml pen ordered sliding scale as directed at meals and before bed: inject subcutaneous before meals and before bedtime: fingerstick blood sugar (FSBS) checks less than 100 = hold and initiate hypoglycemia protocol, less than 250 = 0 unit, 250-299 = 4 units, 300-350 = 6 units, greater than 350 - 8 units, greater than 500 - call provider.
-There was no documentation on 05/0324 at 8:00pm, 05/06/24 at 8:00pm, 05/07/24 at 4:00pm and 8:00pm, 05/08/24 at 4:00pm, and 05/09/24 at 8:00am.
-On 05/03/24 at 12:00pm FSBS was measured at 294 but 8 units were documented as administered.
-On 05/03/24 at 4:00pm FSBS was measured at 220 but 37 units were documented as administered.
-On 05/06/24 at 12:00pm FSBS was measured at 252 but 12 units were documented as administered.
-On 05/21/24 at 8:00am FSBS was measured at 168 but 8 units were documented as administered.
-On 05/21/24 at 12:00pm FSBS was measured at 209 but 8 units were documented as administered.
-On 05/21/24 at 4:30pm FSBS was measured at 203 but 8 units were documented as administered.
-On 05/22/24 at 12:00pm FSBS was measured at 334 but 14 units were documented as administered.
-On 05/22/24 at 4:30pm FSBS was measured at 232 but 8 units were documented as administered.
-On 05/23/24 at 12:00pm FSBS was measured at 256 but 12 units were documented as administered.

Interview with Resident #2 on 05/28/24 at 10:00am revealed:
-She was unaware her medications were not administered correctly.
-She was unaware of issues with blood sugar.

Interviews with a MA on 06/28/24 and 7/12/24 at 10:00am revealed:
-She followed the medication orders in the eMAR.
-She was unaware Resident #2's insulin was being administered incorrectly.

Interviews with the RCC on 05/28/24 at 4:00pm and 06/28/24 at 3:15pm revealed:
-She was not aware of issue with insulin or FSBS.
-She was responsible for contacting the appropriate medical providers as needed.
-She would have contacted provider via telehealth if needed.
-There was no record of provider notification.

Interview with the Administrator on 06/28/24 revealed:
- He was unaware that Resident #2's insulin was being administered incorrectly.
-The facility had a new medication passing computer system.
-The staff were trained on the new system.
-The RCC was responsible for contacting providers when needed.

b.Review of Resident #2's May 2024 eMAR revealed:
There was an entry for Insulin Lispro 100 unit/ml pen ordered 8 units sub-q with meals (order discontinued on 05/24/24):
-Per MAR, documentation for each pass should include time administered, site given, and FSBS as taken before administration.
-MAR showed no documentation on 05/03/24 at 11:30am, 05/07/24 at 4:30pm, 05/08/24 at 4:30pm, 05/09/24 at 8:00am, 05/09/24 at 11:30am, 05/22/24 at 11:30am, and 05/23/24 at 11:30am.

Interview with Resident #2 on 05/28/24 at 10:00am revealed:
-She was unaware of any medication administration errors.
-She was unaware of issues with blood sugar.

Interview with a MA on 06/28/24 and 7/12/24 at 10:00am revealed:
-She followed the medication orders in the eMAR.
-She was not aware that Resident #2's insulin was not administered correctly.

Interviews with the RCC on 05/28/24 at 4:00pm and 06/28/24 at 3:15pm revealed:
-She was not aware of issue with insulin or FSBS.
-She was responsible for contacting the appropriate medical providers as needed.
-She would have contacted provider via telehealth if needed.
-She may have contacted the provider but have no record of provider notification.

Interview with the Administrator on 06/28/24 at 3:45pm revealed:
- He was not aware that Resident #2's insulin was being administered incorrectly.

-The facility had a new medication passing computer system. -Staff were trained on the new system. -The RCC was responsible for contacting providers when needed.		
III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 13F.0902(b) HEALTH CARE Rule/Statutory Reference: The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. Level of Non-Compliance: A1 Violation Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the routine and acute health care needs for 2 of 6 sampled residents (#1, #2) as evidenced by failure to follow-up on referral for routine suprapubic catheter care and wound care for the catheter site (#1) resulting in a wound on Resident #1 and failure to notify the provider of elevated blood glucose (#2). The findings are: 1. Review of Resident #1's current FL2 dated 04/18/24 revealed: -Diagnoses included multiple sclerosis (MS) and type 2 diabetes mellitus. -The resident was semi-ambulatory and required assistance with bathing and dressing. Review of Resident #1's Resident Register dated 04/15/24 revealed: -Resident #1 was admitted to the facility on 04/15/24. -He had a suprapubic catheter (a hollow, flexible tube used to drain urine from the bladder from a cut in the abdomen). -He required assistance with suprapubic catheter care. Review of Resident #1's emergency room (ER) discharge note dated 04/17/24 at 07:30am: -The resident was sent to the ER from the facility at 3:15am via ambulance. -He was seen in the ER for possible blood in his urine "secondary to a dirty suprapubic catheter" and required replacement of the catheter. -Discharge diagnoses included urinary tract infection (UTI). -He was discharged with orders for a course of oral antibiotics, additional urine culture to identify specific bacteria, and an order to return if symptoms worsen. -He was discharged back to the assisted living facility at 7:30am. Interviews with the Resident Care Coordinator (RCC) on 05/28/24 at 4:00pm, 06/28/24 at 3:15pm, 07/12/24 at 10:34am, and 07/29/24 at 1:35pm revealed: -Resident #1 informed her he was in a lot of pain while completing admission paperwork on 04/17/24.	☐ POC Accepted_____ *DSS Initials* IDR Submitted. Referral and follow up for provider and care orders is to be implemented in accordance with provider written orders. Facility provides further training to enhance competency in the areas of referral and follow up. Facility to facilitate communication between staff and providers to ensure safe and effective care is provided.	08/28/24

-The resident was unable to complete the paperwork with the RCC due to the pain.
-He was sent to the Emergency Room (ER) for a second time on 04/17/24 due to the increasing pain and discomfort.

Review of Resident #1's hospital discharge summary dated 04/17/24 revealed:
-On 04/17/24 at 5:23pm, he was transferred to the ED for a second time for reports of "mild to moderate distress with left-sided flank pain and low-grade fever".
-His laboratory test results showed "multi-drug resistant bacteria present" in the previously diagnosed urinary tract infection (UTI).
-He was diagnosed with sepsis and admitted to the hospital unit on 04/17/24.
-He stated to providers he had been experiencing UTI symptoms for over two weeks.
-He was discharged to a skilled nursing facility (SNF) for short term rehab on 04/24/24 with a plan to return to the facility after the course of IV antibiotic treatment.

Interviews with the RCC on 05/28/24 at 4:00pm, 06/28/24 at 3:15pm, 07/12/24 at 10:34am, and 07/29/24 at 01:35pm revealed:
-Resident #1 returned from SNF on 05/16/24.
-The resident was sent to the ER again on 05/17/24 at 6:00pm due to him being concerned about his catheter.
-He told RCC the catheter was leaking from the site on his lower abdomen.
-She was not aware of any catheter care orders when he returned to the facility from the SNF.

Review of Resident #1's ER discharge summary dated 05/17/24 revealed:
-He was seen in ER on 05/17/24 for leaking from the suprapubic catheter.
-Laboratory test results showed presence of multi drug resistant bacteria, and he was prescribed antibiotic course.
-He was discharged back to the facility on 05/17/24.

Review of Resident #1's hospital discharge record dated 05/23/24 revealed:
-He presented to the hospital on 05/23/24 due to "urine culture showed multidrug resistant organisms" and he complained of malaise and "increased suprapubic pain".
-A new wound was found near suprapubic catheter site on 05/23/24 that was not present at previous hospitalizations.
-The wound was noted to be "ulceration of skin at 3o'clock location".
-The provider noted the new wound could be the source of the increase in pain.
-Discharge orders included "Needs outpatient urology follow-up ASAP and regular exchange of suprapubic catheter at facility".
-The provider called the RCC at the facility to ensure the catheter care and changing would be done.
-Received verbal confirmation from the RCC that catheter care would be provided by a home health nurse if ordered.

-Discharge orders "recommend wound care be implemented locally to the suprapubic cath insertion site as he does have an erosion/ ulceration forming and this is potentially a source of infection as well as a source of his pain".
-The provider noted "Suprapubic catheter in place with ulcerated erosion wound extending left laterally approximately 3:00, tender to touch, no significant drainage or surrounding redness other than this local wound".
-The resident was discharged back to the facility on 05/23/24.

Review of Resident #1's ER discharge summary dated 05/28/24 revealed:
-He was seen in the ER on 05/28/24 for generalized weakness and dizziness.
-The provider also noted "erosion at 3:00, purulent drainage coming out around the catheter, mild erythema in the area is tender".
-The provider consulted with urology regarding the skin breakdown and wound care was ordered.
-The resident reported to the provider that family member was providing all care while at the assisted living facility.
-The resident was given orders to discharge to a SNF.

Review of Resident #1's record at the facility on 05/28/24 revealed:
- There was no documentation related to Resident #1's suprapubic catheter on 05/17/24 when he was readmitted to the facility from the SNF.
- There was also no care plan, no Licensed Health Professional Support (LHPS) documentation, and no staff progress notes.

Interview with Resident #1 at the hospital on 05/29/24 at 9:40am revealed:
-He was in the hospital due to "not doing well" at the facility as the staff were not providing him catheter care.
-He had ongoing issues with a UTI and his catheter.
-His family member who also resided at the facility had to provide catheter care and empty his catheter bag.
-He was experiencing frequent pain, both related to catheter and his MS.

Interview with Resident #1's family member on 05/28/24 at 3:30pm revealed:
-She shared a room with Resident #1 at the facility.
-She stated she had to empty his catheter bag as the staff did not do this task.
-The facility staff never informed her Resident #1 was referred to home health to assist with care.
-Resident #1 was never seen by home health in this facility for catheter care or wound care.
-She stated that Resident #1 was frequently in pain.

Review of an email from the home health representative dated 07/09/24 revealed:
-Resident #1 had been referred by the Primary Care Provider (PCP) for concerns about his catheter on 05/27/24.

-The resident was seen by the provider on 05/27/24 via telehealth and was approved for home health care for catheter care and wound care services.
-There was no record of a referral for catheter care or wound care for Resident #1 prior to 05/27/24.

Interviews with the RCC on 05/28/24 at 4:00pm, 06/28/24 at 3:15pm, 07/12/24 at 10:34am and 07/29/24 at 1:35pm revealed:
-She completed Resident #1's admission.
-She was aware the resident required assistance with emptying his catheter when he was admitted.
-She believed home health would need to be present for all other catheter care.
-She believed she made a referral for home health before 05/27/24 and the resident was not present when home health came to assess.
-She could not provide documentation showing a referral had been made prior to 05/27/24.
-After Resident #1 returned to the facility on 05/17/24, he continued to complain of pain.
-She knew this because he was asking for his PRN pain medications.
-She was aware of orders for antibiotics following the 05/17/24 and 05/23/24 hospitalizations.
-She was unaware of orders for wound care.
-She observed no wounds when assisting Resident #1 with his catheter.
-She was responsible for contacting the PCP for clarification on orders.
-She was responsible for reading discharge orders and processing any new treatment orders.
-She would have contacted the provider to clarify the orders if she had known about the wound care order.
-The medical provider contracted for the facility did not see the resident during his stay because the resident was at the hospital during the days the provider was present.
- She could provide any documentation she had spoke with Resident #1's PCP about catheter care.

Interview with a medication aid (MA) on 05/31/24 at 10:30am and 07/12/24 at 10:00am revealed:
-Prior to his hospitalization on 05/28/24, Resident #1 verbalized pain but would not state where the pain was located as he was not speaking much.
-A family member of the resident also stated he was in pain.
-He was grimacing and groaning at times.
-She informed the RCC of increasing pain that was not helped by the medication per resident.
-Resident #1 had been out of the facility for long periods of time but received assistance with emptying urine from the catheter bag when he requested.
-She was unaware the resident had a wound.

Interview with one of the facility Owners on 07/05/24 at 9:40am revealed:
-She was also a registered nurse (RN).

-She was working on-site at the facility in May 2024 reviewing LHPS assessments.
-She had minimal interactions with Resident #1.
-Resident #1 was only in the facility for 7-10 days over a two-month period.
-She saw Resident #1 for a few minutes when administering his IM antibiotic.
-She was unaware of any catheter care concerns.
-Any catheter care would have been provided by the home health nurse.
-She stated any issues with home health nurse referrals were the responsibility of the RCC.

Interview with the Administrator on 06/28/24 at 3:45pm revealed:
-The RCC was responsible for reviewing discharge notes for new orders.
-The RCC would have to be asked why the resident was not seen by home health.
-The RCC would have to be asked questions regarding the provision of care.
-Resident #1 was in and out of the facility due to the frequent hospitalizations.
-According to information provided by the RCC, the resident was only in facility for 6 days due to hospitalizations.

Attempted interview with Resident #1's Primary Care Provider (PCP) on 05/28/24 at 4:00pm was unsuccessful.

2.)Review of Resident #1's current FL2 dated 04/18/24 revealed:
-Diagnoses included multiple sclerosis (MS) and type 2 diabetes mellitus.
-The resident was semi-ambulatory and required assistance with bathing and dressing.
-The resident had an order for Hydrocodone-acetaminophen 5-325mg, take 1 tablet every 6 hours as needed for pain.

a. Review of Resident #1's May 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Hydrocodone-acetaminophen 5-325mg - take 1 tablet by mouth every 6 hours as needed for pain.
-There was no documentation hydrocodone-acetaminophen was administered after the 05/27/24 at 5:21am dose.
-There was no documentation that the provider or pharmacy was notified the resident had run out of medications.

Review of Resident #1's facility record on 05/28/24 revealed no care notes for the resident since his admission on 04/17/24.

Interview with Resident #1 on 05/29/24 at 9:40am revealed:
-He had gone without his pain medication as they had run out.
-Had no doses after early morning on 05/27/24.
-Was only "a day or two but I have MS, when I need pain medication, I really need it".
-He was brought to the hospital on 5/28/24 at 2am.

-Facility staff told him his medication had run out.
-One staff told him it had not been ordered.
-Another staff reported it had been thrown away.
-He does not know what actually happened but that it did not seem appropriate.
-He was told repeatedly that the facility forgot to order the medication beginning on 05/27.

Interview with the facility's contracted pharmacy on 06/25/24 at 3pm revealed:
-The facility received routine ordered medications on the same cycle each month.
The medication pack cycle for this facility started on the 15th of each month for all pill form medications routinely ordered.
-The pharmacist stated that it is the responsibility of the facility to reorder PRN medications.
-The medication was not reordered since the resident arrived at the facility on 05/17/24.

Interview with a MA on 06/28/24 and 7/12/24 at 10:00am revealed:
-The resident ran out of his pain medication.
-Resident #1 reported pain after he ran out of medication.
-The resident's family member also reported he was in pain.
-She could not reorder controlled medications on the eMAR system, so she told the RCC the resident was out of his pain medication.

Interviews with the RCC on 05/28/24 at 4:00pm, 06/28/24 at 3:15pm, and 07/12/24 at 10:34am revealed:
-The resident reported pain frequently.
-She knew Resident #1 had run out of medication.
-She was responsible for reordering medications.
-She requested refills from the provider if needed.
-She was responsible for contacting the appropriate medical providers as needed.
-She could not say why she had not re-ordered the medication or contacted the PCP.

Interview with the Administrator on 06/28/24 at 3:45pm revealed:
-The Administrator stated they were unaware of issues with Resident's medications.
-The RCC is responsible for contacting the providers and reordering medications.

b. Review of Resident #1's May 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Buspirone HCL 30mg tablet - 1 tablet by mouth twice daily, used to treat anxiety.
-Staff documented the medication was "on order from pharmacy" for those missed administrations.
-Buspirone HCL was documented as administered on 05/22/24 at 6:00pm and 05/23/24 at 6:00pm.
-The resident was not administered this medication on 9 out of 21 administration opportunities.
-There was no documentation that the provider was notified of the

missed doses.

Review of Resident #1's facility record on 05/28/24 revealed no care notes for the resident since his admission on 04/17/24.

Interview with Resident #1 on 05/29/24 at 9:40am revealed:
-He was concerned about his medication.
-He spoke with staff about medication and that they just blamed one another.
-The resident reported that he does not know what happened but that it did not seem appropriate.

Interview with a MA on 06/28/24 and 7/12/24 at 10am revealed:
-She followed the medication orders in the eMAR.
-She was not aware of that Resident #1's Buspirone was not being administered correctly.

Interviews with the RCC on 05/28/24 at 4:00pm, 06/28/24 at 3:15pm, and 07/12/24 at 10:34am revealed:
-She did not think Resident #1 had missed any Buspirone.
-She was responsible for contacting the appropriate medical providers if medications were missed.
-She would have contacted provider via telehealth if needed.
-She had no record of provider notification.

Interview with the Administrator on 06/28/24 at 3:45pm revealed:
-The facility had a new medication passing computer system.
-The staff were trained on the new system.
-The RCC was responsible for contacting providers when needed.

b. Review of Resident #2's current FL2 dated 04/18/24 revealed:
-Diagnoses included type 2 diabetes, anemia, COPD, and obesity.
-The resident was semi-ambulatory and required assistance with bathing and dressing.

Review of physician signed endocrinology visit notes for Resident #2 dated 04/10/24 revealed:
- Fingerstick blood sugar checks were ordered to be taken 4 times daily before meals, 2 hours after meals, and before bedtime.
- Notify provider if fasting blood sugar was above 150 three days in a row.

Review of Resident #2's May 2024 electronic medication administration record (eMAR) revealed:
- There was no documentation of FSBS taken 2 hours after meals.
- Fasting blood sugar was above 150 on 24/28 opportunities.

Interview with Resident #2 on 05/28/24 at 10:00am revealed she was unaware of issues with blood sugar.

Interviews with the RCC on 05/28/24 at 4:00pm, 06/28/24 at 3:15pm, and 07/12/24 at 10:34am revealed:
-She was not aware there were any issues with Resident #2's FSBS or that it wasn't being measured as ordered.

-She was responsible for contacting the medical providers as needed. -She would have contacted the provider via telehealth if needed. -There was no record of provider notification. Interview with the Administrator on 06/28/24 at 3:45pm revealed: - He was not aware of any issues with Resident #2's FSBS orders. -The facility had a new medication passing computer system. -The staff were trained on the new system. -The RCC was responsible for contacting providers when needed. The facility failed to contact the provider for Resident #1 related to suprapubic catheter care which resulted in resident developing a UTI with multiple and frequent hospitalizations and wound at the catheter site. 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 05/31/24 for this violation DATE OF CORRECTION FOR THE A1 VIOLATION SHALL NOT EXCEED		

IV. Delivered Via:	**Certified Mail #:**	Date:
DSS Signature:		Return to DSS By:

V. CAR Received by:	Administrator/Designee (print name):	
	Signature:	Date:
	Title:	

VI. Plan of Correction Submitted by:	Administrator (print name): Gage Boardingham	
	Signature:	Date: 08/19/2024

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ ***POC Not Accepted***	By:	Date:
Comments:		
☐ ***POC Accepted***	By:	Date:
Comments:		

VIII. Agency's Follow-Up	By:		Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:	
Comments:			

* *For follow-up to CAR, attach Monitoring Report showing facility in compliance.*