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	HAL092219	A. BUILDING: _____ B. WING _____	R-C 11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARINA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on November 09, 2021 - November 10, 2021 and November 12, 2021.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 9 of 9 exit doors accessible for residents' use were equipped with a sounding device that activated for the safety of 1 of 1 sampled resident who was disoriented and who eloped from the facility without staff knowledge (Resident #3). The findings are: Observations upon entrance to the facility on	D 067		

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11/09/21 at 9:00am and intermittently throughout the day until 5:30pm revealed there was no alarm sounding device when the front/entrance door to the facility was opened.

Observations upon entrance to the facility on 11/10/21 at 7:00am and intermittently throughout the day until 6:00pm revealed there was no audible sounding device when the front door was opened.

Observation of the entrance door on 11/12/21 at 8:00am revealed there was no audible sounding device when the front door was opened.

Observation of the exit door at the end of the hallway on D hall on 11/12/21 at 1:27pm and intermittently throughout the day until 6:30pm revealed there was no audible sounding device when the door was opened.

Observation of a second exit door on D hall on 11/12/21 at 1:28pm revealed and intermittently throughout the day until 6:30pm there was no audible sounding device when the door was opened.

Observation of the double doors within the main dining hall on 11/12/21 at 1:30pm and intermittently throughout the day until 6:30pm revealed there was no audible sounding device when the door was opened.

Observation of the exit door on A hall on 11/12/21 at 1:32pm and intermittently throughout the day until 6:30pm revealed there was no audible sounding device when the door was opened.

Observation of the first exit door on B hall on 11/12/21 at 1:33pm and intermittently throughout

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the day until 6:30pm revealed there was no audible sounding device when the door was opened.

Observation of the second exit door on B hall on 11/12/21 at 1:34pm and intermittently throughout the day until 6:30pm revealed there was no audible sounding device when the door was opened.

Observation of the third exit door on B hall on 11/12/21 at 1:35pm and intermittently throughout the day until 5:30pm revealed there was no audible sounding device when the door was opened.

Review of Resident #3's FL-2 dated 01/18/21 revealed:
-Diagnoses included mental confusion.
-She was intermittently disoriented.
-She was ambulatory, and an assistive device for ambulation was not indicated.

Review of Resident #3's care plan dated 01/18/21 revealed:
-She was not an elopement risk.
-She required a secured environment.

Review of Resident #3's primary care provider's (PCP) note dated 01/25/21 revealed:
-Diagnoses included dementia without behavioral disturbance, unspecified dementia type.
-There was an order to start Aricept 5mg at bedtime (Aricept is used to treat Alzheimer's disease).
-Her dementia was mild.
-She had no recent falls, agitation, or anxiety since being at the facility.
-She currently walked unassisted.

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D 067	Continued From page 3 Review of Resident #3's PCP note dated 02/15/21 revealed: -Her dementia was stable and was managed at the facility with staff assistance with her activities of daily living. -She also took Aricept 5 mg at bedtime. Interview with the Executive Director on 11/12/21 at 3:37pm revealed: -The facility's resident population varied from completely oriented to residents who were intermittently disoriented and had the early stages of Alzheimer's disease. -Every day, 7 days a week, from 7:00pm-7:00am the door alarms at each exit door would activate automatically and the doors were locked. -Every day, 7 days a week, from 7:00am-7:00pm the door alarms were not activated, and the exit doors of the facility were not locked. -The facility's process in place to prevent a resident's elopement from the facility was all staff were responsible to monitor resident traffic through the exit doors of the facility. -Residents could walk outside on facility grounds. -The residents who walked outside on facility grounds would let staff know this prior to walking outside. -There were no residents who lived within the assisted living part of the facility who had wandering behaviors or who were an elopement risk. -She was not aware of the regulation related to the exit doors accessible to residents included both residents who were determined by a physician have wandering behaviors or disoriented. -She was trained by her mentor residents could continue to live on assisted living unit they reached a criteria #4 on the Functional Assessment Staging Scale (FAST) (the FAST	D 067		

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scale is designed to be used to see how residents with Alzheimer's disease are progressing deeper into the disease.)
-Criteria #4 on the FAST scale was the decreased ability to perform complex tasks.
-With having all the exit door sounding devices silenced when the door was opened from 7:00am-7:00pm, she had resident safety concerns.
-The road which ran parallel to the facility was a "busy" road for a resident who was intermittently confused to be walking down without being accompanied by staff.
-Today, 11/12/21, was the first time she became aware of Resident #3's elopement from the facility on 09/05/21.
-Resident #3 had mild dementia but it was not safe for her to walk alone to the local fast food restaurant.
-She had concerns for residents with dementia without the sounding device at the front entrance, but all staff were responsible for monitoring the exit doors.

Telephone interview with the Resident #3's primary care provider on 11/12/21 at 5:12pm revealed:
-Resident #3's diagnoses included Parkinson's disease and "very mild" dementia.
-When she came to the facility to see Resident #3, she would answer questions appropriately.
-There was no need for Resident #3 to be moved to the Special Care Unit.
-She had some concerns related to Resident #3's elopement dated 09/05/21 from the facility to a local fast food restaurant without the staff's knowledge.
-The local fast food restaurant was a "little too far" for Resident #3 to walk from the facility unaccompanied.

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D 067	Continued From page 5 -There were safety concerns for Resident #3 due to the road that ran parallel to the facility was a busy road where a school and a daycare were located. -She had concerns due to the facility not activating all exit door sounding devices until 7:00pm each day. -Residents who were disoriented or had wandering behaviors could leave the facility without the staff's knowledge. _____ The facility failed to ensure 9 of 9 exit doors were equipped with a sounding device that activated when doors were opened for 1 of 1 sampled resident residing at the facility who was assessed to be intermittently disoriented which resulted in a resident with known disorientation eloping from the facility on 09/05/21 without staff knowledge (Resident #3). This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/15/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 27, 2021.	D 067		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	D 270		

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This Rule is not met as evidenced by:
FOLLOW-UP TO TYPE A2 VIOLATION.

The Type A2 Violation was abated.
Non-compliance continues.

Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with the residents' assessed needs for 2 of 7 sampled residents (#3 and #7) related to a resident who was intermittently disoriented and eloped from the facility without staff knowledge (#3) and related to a resident smoking in their bathroom (#7).

The findings are:

1. Review of Resident #3's FL-2 dated 01/18/21 revealed:
-Diagnoses included mental confusion.
-She was intermittently disoriented.
-She was ambulatory, and an assistive device was not indicated.

Review of Resident #3's care plan dated 01/18/21 revealed:
-She was not an elopement risk.
-She required a secured environment.

Observations on 11/10/21 at 2:00pm revealed:
-There was a 2-lane road leading to the facility.
-The speed limit on the road outside of facility grounds was 25 miles per hour.
-Upon leaving the facility grounds there was no immediate sidewalk on the right side of the road; the sidewalk began about ¼ mile from the facility.
-There was a sidewalk on the left side of the road which was on the opposing side of the road from

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the facility.
-There was a school on right and a child daycare on the left side of the road.
-There was a local fast food restaurant approximately a ½ mile from the facility on the left.
-There was a 4-lane traffic intersection approximately 1 mile away from the facility.

Telephone interview with Resident #3's family member on 11/12/21 at 12:55pm revealed:
-Resident #3 transitioned to assisted living from independent living in January 2021.
-The decision was made to move her to the facility because she was not making "good" decisions.
-She would leave the gas stove on at her house; and she was leaving her house and crossing 5 lanes of traffic.
-The end of September/beginning of October 2021, Resident #3 reported to her she left the facility with $20 to walk to a local fast food restaurant approximately ¼ mile from the facility.
-Resident #3 propped the side exit door open with a twig within the hallway of where her room was located.
-She was gone from the facility for approximately 2 hours.
-Resident #3's family member had made 4 calls (the dates of the phone calls were not provided) to the Executive Director to report Resident #3's elopement without success.
-She was concerned about Resident #3's safety; she was not aware of her surroundings.
-She had balance issues related to her Parkinson's diagnosis.
-She was worried Resident #3 could have a fall and could have a head injury.
-The main reason for Resident #3 being placed at the facility was her concern of Resident #3's

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safety.
-She expected the facility to provide supervision to Resident #3 and keep her safe.

Interview with Resident #3 on 11/12/21 at 1:37pm revealed:
-She had eloped once from the facility on Labor Day weekend.
-On 09/05/21, the residents were served an early dinner and she walked out the exit door located at the end of her hallway without incident.
-She left the facility to walk up the street to a local fast food restaurant to buy a hamburger.
-She was gone approximately 1 hour from the facility and she returned to the facility without staff knowing she was ever gone.
-She did not believe "anyone" checked on her at all.

Interview with the Executive Director on 11/12/21 at 3:37pm revealed:
-The facility's resident population varied from completely oriented to residents who were intermittently disoriented and had the early stages of Alzheimer's disease.
-The standard of care for residents' rounds was every two hours by staff.
-She expected staff members to alternate residents' rounds with each other so ultimately the residents' rounds could be completed every 1 hour.
-The residents' rounds were not documented by staff.
-She expected staff when completing residents' rounds to check in each residents' room and verify their location and offer them assistance, for example, bathroom assistance.
-All staff were responsible to monitor resident traffic through the exit doors of the facility.
-Residents could walk outside on facility grounds.

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-The residents who walked outside on facility grounds would let staff know this prior to walking outside.
-She did not think there were any residents who lived within the assisted living part of the facility who had wandering behaviors or who were an elopement risk.
-There were no residents who were receiving "official" increased supervision monitoring except for one other resident.
-Resident #3 was not receiving increased supervision monitoring.
-Resident #3 had not been identified as an elopement risk during the admission process and she was not aware of Resident #3's elopement on 09/05/21 until today, 11/12/21.
-She had observed a twig placed at the exit door at the end of Resident #3's hallway previously but she could not recall the date.
-She removed the twig, but increased supervision monitoring was not implemented.
-She had concerns related to Resident #3 leaving the facility on 09/05/21; the road which ran parallel to the facility was a "busy" road for a resident who was intermittently disoriented to be walking down without being accompanied by staff.
-Resident #3 had mild dementia but it was not safe for her to walk alone to the local fast food restaurant.

Telephone interview with the Resident #3's primary care provider (PCP) on 11/12/21 at 5:12pm revealed:
-Resident #3's diagnoses included Parkinson's disease and she had "very mild" dementia.
-Resident #3 would answer questions appropriately.
-There was no need for Resident #3 to be moved to the Special Care Unit.

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D 270	Continued From page 10 -She had some concerns related to Resident #3's elopement dated 09/05/21 from the facility to a local fast food restaurant without the staff's knowledge. -The local fast food restaurant was a "little too far" for Resident #3 to walk from the facility unaccompanied. -There were safety concerns for Resident #3 due to the road that ran parallel to the facility was a busy road where a school and a daycare were located. -She expected residents who were disoriented or had wandering behaviors to be supervised by staff. Requests were made for the facility's supervision policy on 11/09/21 at 1:58pm and on 11/12/21 at 11:08am but was not received prior to survey exit on 11/12/21. 2. Review of the facility's Resident Smoking Policy dated 04/01/15 and revised 11/15/17 revealed: -It is the policy of the company to promote the rights, health, and safety of all residents. -Smoking poses serious risks to the residents' health and safety. -Due to the increased risk of fire and the known health effects of secondhand tobacco smoke, smoking is prohibited on the entire premises, including inside the residential units, all common areas and areas within 30 feet of entrances, windows, doors, and air-intake units, by all persons. -However, we acknowledge and respect an individual's right to smoke by providing a designated outdoor smoking area. -The resident consents and agrees to abide by the smoking policy. -The resident agrees to follow all rules in the	D 270		

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smoking policy, including NOT SMOKING in the facility.
-The resident agrees to abide by the consequences as set in the smoking policy for non-compliance.
-Residents shall not smoke within 5 feet of oxygen equipment and/or other potentially hazardous/flammable items.
-A smoking assessment will be completed upon admission and with any change of condition to ensure the resident can safely smoke.
-There was no documentation of specific consequences for non-compliance in the smoking policy.

Review of Resident #7's current FL-2 dated 02/17/21 revealed:
-Diagnoses included coronary artery disease, hypertension, end stage renal disease, and chest pain,
-The resident was semi-ambulatory and hard of hearing.

Review of Resident #7's Resident Register dated 11/20/20 revealed:
-The resident was admitted to the facility on 11/20/20.
-The resident's personal habits included smoking.

Review of Resident #7's health and service evaluation dated 06/23/21 revealed:
-The resident currently smoked.
-The resident walked occasionally during the day but very short distances.
-The resident spent the majority of each shift in bed or in chair.
-The resident was oriented to person, place, time, and situation.
-The resident may require prompts/cues to use assistive device.

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D 270	Continued From page 12 -The resident was documented as legally blind. Review of Resident #7's assessment and care plan dated 11/10/21 revealed: -The resident was ambulatory with a wheelchair or walker. -The resident was blind in his right eye. -The resident was oriented and had adequate memory. -There was no documentation regarding the resident's care needs or supervision needs for smoking. Review of Resident #7's assessments revealed no documentation of a smoking assessment. Observation of the B hall on 11/09/21 at 10:54am revealed: -There was a male sitting in a wheelchair in the hallway near the country kitchen/activity room and near the entrance to resident room B4. -The resident had a portable oxygen tank and was wearing oxygen at 2 liters per minute. -There was a strong odor of cigarette smoke in the hallway near the resident. Interview with the resident sitting in the hallway on 11/09/21 at 10:54am revealed: -Resident #7 lived in resident room B4 and smoked in the bathroom in the room. -He smelled smoke in the hallway outside Resident #7's room frequently. -He was concerned that Resident #7 smoked in the room because he lived next door and used oxygen. -He thought facility staff were aware the resident smoked in his room. Interview with a medication aide (MA) on 11/09/21 at 10:58am revealed:	D 270		

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D 270	Continued From page 13 -It was not unusual to smell smoke in that area of B hallway. -There was a designated smoking area outside of the exit door at the end of the B hall. -She thought the smoke odor may come from residents opening the exit door at the end of the B hall and smoke entering the building from the designated outside smoking area. Observation of Resident #7's room on 11/09/21 at 11:05am revealed: -Resident #7 was sitting in a wheelchair in his room near the entrance to the bathroom. -There was a slight cigarette smoke odor in the room. -No cigarettes or ashes were observed in the bedroom. -The bathroom could not be seen due to the resident blocking the entrance to the bathroom with his wheelchair. -The roommate was not currently in the room. Interview with Resident #7 on 11/09/21 at 11:05am revealed: -He smoked cigarettes but the facility staff did not let anyone smoke inside. -Residents were supposed to smoke outside. -He did not smoke in his room but facility staff would get on him because they thought he smoked in his room. -He told facility staff that when he came inside from smoking, the smoke odor was in his clothes. -He kept his own cigarettes and lighters with him. Interview with Resident #7's roommate on 11/10/21 at 7:55am revealed: -Resident #7 smoked in their room. -Resident #7 got up all during the night to smoke and Resident #7 would smoke in the bedroom or in the bathroom.	D 270		

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D 270	Continued From page 14 -Resident #7 would "put out" the cigarettes on the toilet seat, which caused black burn marks on the toilet seat. -Facility staff had "caught" Resident #7 smoking in the room a few times but Resident #7 always denied it. -Resident #7 was last "caught" by staff smoking in the room a couple of weeks ago. Observation of Resident #7's bathroom on 11/10/21 at 2:12pm revealed: -There was an area on the inner rim of the toilet seat approximately 6 inches long with multiple black cigarette burn marks. -There were 2 areas on the floor near the toilet with small round black marks. -There was scattered brown debris around the sink that was tobacco flakes from a cigarette. Interview with a second MA on 11/10/21 at 5:27pm revealed: -She "caught" Resident #7 smoking in his room about a month ago. -The resident came out of his bathroom and she did not see him smoking but she could smell "heavy" smoke in the room. -She did not check the bathroom that day to look for signs of smoking. -She did not document the incident. -She reported it to a former supervisor and the supervisor was going to talk to the resident. -Residents were supposed to smoke outside at the end of B hall. -Resident #7 was not on any supervision checks to her knowledge. -She had not been instructed to do any supervision checks on Resident #7. Interview with the Activities Director (AD) / MA on 11/12/21 at 4:00pm revealed:	D 270		

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-Her office was in the country kitchen/activity room across the hall from Resident #7's room.
-She sometimes smelled smoke while she was in her office.
-She would go into Resident #7's bedroom and the resident would be coming out of the bathroom and she could smell cigarette smoke.
-The resident would deny smoking in his room.
-She last smelled cigarette smoke coming from Resident #7's room last week.
-She thought the resident was currently out of cigarettes.
-She saw the burn marks on Resident #7's toilet seat but she was unsure how long the burn marks had been there.
-She thought the resident flushed the cigarette butts down the toilet.
-There was no specific system to check on or supervise the resident but she usually checked on Resident #7 about every 1 to 2 hours.

Interview with the Executive Director (ED) on 11/10/21 at 5:42pm revealed:
-She was aware Resident #7 smoked in his room.
-She had been discussing with the Regional Director of Operations about doing a 30-day discharge notice due to the resident smoking in his room but that had not been decided.
-During the middle of last month, she walked in Resident #7's room and "caught" him coming out of the bathroom with a strong smell of smoke around 8:00pm.
-The resident denied smoking in the bathroom when she questioned him.
-She checked the resident's bathroom at that time and she saw cigarette ashes in the sink.
-She contacted the resident's family member immediately about the resident smoking in the room.
-She did not think to put any supervision checks

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D 270	Continued From page 16 in place for Resident #7 because it "never crossed my mind". -She was not sure what the facility's smoking policy was but she was trying to get a copy from the corporate office. -She did not know if a smoking assessment had been completed for the resident. Interview with a third MA on 11/12/21 at 8:54am revealed: -She had never observed Resident #7 smoke in his room but she had smelled smoke in the resident's room. -Resident #7 sometimes went outside to smoke at the end of B hall or outside the exit of the country kitchen/activity room across from his room. -The facility staff just started doing 1-hour checks on Resident #7 yesterday, 11/11/21. -The facility staff were supposed to go in the resident's room and look around to see if there was any indication of smoking in the room. -She had not been instructed to supervise Resident #7 for smoking prior to yesterday, 11/11/21. Interview with the ED on 11/12/21 at 1:38pm revealed: -She could not locate a smoking assessment for Resident #1 because one was never done. -She was not aware a smoking assessment was supposed to be done according to the smoking policy and she was not aware of a form to use for the smoking assessment.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up	D 273		

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to meet the routine and acute health care needs of residents.

This Rule is not met as evidenced by:
FOLLOW-UP TO TYPE A2 VIOLATION.

Based on these findings, the previous Type A2 Violation was not abated.

Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 2 of 5 sampled residents (#1, #2) related to not scheduling a follow-up appointment with the cardiology provider, not obtaining labwork as ordered, and not notifying the provider of weight gain for a resident with two hospitalizations for fluid overload and an exacerbation of congestive heart failure (#1); and not notifying the provider of blood sugars greater than 300 as ordered for a resident with diabetes who was receiving insulin (#2).

The findings are:

1. Review of Resident #1's current FL-2 dated 09/27/21 revealed diagnoses included acute on chronic systolic congestive heart failure, acute renal failure, atrial fibrillation, and coronary artery disease.

a. Review of Resident #1's hospital discharge summary and discharge instructions dated 09/07/21 revealed:
-The resident's date of admission to the hospital was 08/31/21 and the discharge date was 09/07/21.
-The resident presented to the emergency room (ER) with shortness of breath and leg swelling.
-The resident reported having shortness of breath

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for 2 weeks and he could not walk to the door without getting short of breath.
-The resident noted he had bilateral lower extremity leg swelling for years but there had recently been new onset leg weeping in the past few weeks and redness.
-Emergency Medical Services (EMS) noted the resident had diminished left lower lung sounds on arrival, noticed weeping legs, and the resident was in atrial fibrillation.
-The resident's discharge diagnoses included acute on chronic systolic congestive heart failure, atrial fibrillation, congestive heart failure exacerbation, shortness of breath, leg swelling, anemia, cellulitis, stage 3 chronic kidney disease, ischemic cardiomyopathy, and hypomagnesemia.
-The resident was to be weighed daily in the morning and record.
-Report to cardiology provider: weight increase of 2 to 3 pounds overnight or 3 to 5 pounds over one week; swelling in the feet, legs, or stomach area; and increased shortness of breath with minimal activity or at rest.

Review of Resident #1's cardiology provider after visit summary dated 09/17/21 revealed:
-The resident was being seen for ischemic cardiomyopathy, atrial fibrillation, heart failure, shortness of breath, and swelling of the ankle, feet, or leg.
-The provider noted the resident's weight had increased 9 pounds since discharge from the hospital on 09/07/21 (194 pounds).
-The resident weighed 203 pounds and 7.8 ounces at the cardiology office on 09/17/21.
-There was an order to record daily weights first thing in the morning, after resident voids, in same undergarments.

Review of Resident #1's hospital discharge

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summary dated 09/27/21 revealed:
-The resident's date of admission to the hospital was 09/23/21 and the discharge date was 09/27/21.
-The resident was diagnosed with acute on chronic congestive heart failure.

Review of Resident #1's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for weight check every week on Monday, Wednesday, and Friday at 8:00am.
-There were 6 weights documented from 09/01/21 - 09/30/21.
-The resident weighed 199.2 pounds on Sunday, 09/19/21 and 202 pounds on Monday, 09/20/21.
-There was no documentation of the 2.8-pound weight gain from 09/19/21 to 09/20/21 being reported to the provider as ordered.

Review of Resident #1's October 2021 eMAR revealed:
-There was an entry for weight check every week on Monday, Wednesday, and Friday at 8:00am.
-There were 11 weights documented from 10/01/21 - 10/31/21.
-The resident weighed 182 pounds on Thursday 10/07/21; 185 pounds on Friday, 10/08/21; 179 pounds on Friday, 10/22/21; and 188 pounds on Wednesday, 10/27/21.
-There was no documentation of the 3-pound weight gain from 10/07/21 to 10/08/21; and the 9-pound weight gain from 10/22/21 to 10/27/21 being reported to the provider as ordered.

Review of Resident #1's November 2021 eMAR revealed:
-There was an entry for weight check every week on Monday, Wednesday, and Friday at 8:00am.
-There were 5 weights documented from

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D 273	Continued From page 20 11/01/21 - 11/10/21. -The resident weighed 181 pounds on Friday, 11/05/21; 188 pounds on Monday, 11/08/21; and 191 pounds on Wednesday 11/10/21. -There was no documentation of the 7-pound weight gain from 11/05/21 to 11/08/21; and the 3-pound weight gain from 11/08/21 to 11/10/21 being reported to the provider as ordered. Interview with Resident #1 on 11/12/21 at 9:05am revealed: -The facility staff did not weigh him or offer to weigh him. -He weighed himself on his bathroom scales every day and he would report the weights to the MAs when they asked him his weight (not sure how often). -He was supposed to weigh first thing in the morning but he usually ate breakfast before he weighed himself. -He documented his weights on his own weight chart. Review of Resident #1's weight chart dated 10/08/21 - 11/12/21 in the resident's room revealed: -The first documented weight was 180.8 pounds on 10/08/21 and the most current documented weight was 184 pounds on 11/12/21. -There were no weights documented from 10/15/21 - 10/16/21. -There was a 2.5-pound increase overnight from 10/18/21 (179.2 pounds) to 10/19/21 (182.7 pounds). -There was a 3-pound increase overnight from 11/01/21 (177 pounds) to 11/02/21 (180 pounds). -There was a 2-pound increase overnight from 11/05/21 (181 pounds) to 11/06/21 (183 pounds). -There was a 3-pound increase overnight from 11/06/21 (183 pounds) to 11/07/21 (186 pounds).	D 273		

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-There was a 2-pound increase overnight from 11/07/21 (186 pounds) to 11/08/21 (188 pounds).
-There was a 4-pound increase overnight from 11/09/21 (187 pounds) to 11/10/21 (191 pounds).

Review of Resident #1's notes to providers revealed no documentation any provider was notified of Resident #1's weight gain on any occasion.

Interview with a medication aide (MA) on 11/12/21 at 12:22pm revealed:
-Resident #1 had scales in his bathroom that the resident used to weigh himself.
-The MAs used the facility scales in the past to weigh the resident but the resident wanted to weigh early in the morning so he used his own scales.
-If the resident had already weighed himself, the MAs just documented what the resident told them he weighed.
-The resident's weight was only documented 3 times a week because that was how it was listed on the eMAR.
-She was not aware of any weight parameters and none were listed on the eMAR.

Interview with the Executive Director (ED) on 11/12/21 at 1:02pm revealed:
-Resident #1's weights should be checked daily and documented as ordered.
-The MAs should use the facility's scales to weigh the resident to ensure accuracy of the weights.
-The MAs should have notified the provider of the resident's weight gain.

Telephone interview with Resident #1's primary care provider (PCP) on 11/12/21 at 5:16pm revealed:
-Resident #1 discharged from the hospital on

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09/07/21 and again on 09/27/21 due to exacerbation of congestive heart failure.
-She only recalled the facility notifying her on 1 or 2 occasions about weight gain for the resident but she could not recall the dates.
-She expected the facility to notify her of weight gains because she could take closer look at the resident to see if she needed to adjust the diuretics (for fluid retention) or if she needed to reach out to the cardiology provider to try to prevent another hospitalization.
-She saw the resident on Monday, 11/08/21, and he had a weight gain at that time.

Attempted telephone interview with Resident #1's cardiology provider on 11/12/21 at 2:10pm was unsuccessful.

b. Review of Resident #1's hospital discharge summary and discharge instructions dated 09/07/21 revealed:
-The resident's date of admission to the hospital was 08/31/21 and the discharge date was 09/07/21.
-The resident presented to the emergency room (ER) with shortness of breath and leg swelling.
-The resident reported having shortness of breath for 2 weeks and he could not walk to the door without getting short of breath.
-The resident noted he had bilateral lower extremity leg swelling for years but there had recently been new onset leg weeping in the past few weeks and redness.
-Emergency Medical Services (EMS) noted the resident had diminished left lower lung sounds on arrival, noticed weeping legs, and the resident was in atrial fibrillation.
-The resident's discharge diagnoses included acute on chronic systolic congestive heart failure, atrial fibrillation, congestive heart failure

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exacerbation, shortness of breath, leg swelling, anemia, cellulitis, stage 3 chronic kidney disease, ischemic cardiomyopathy, and hypomagnesemia.
-The resident had a return appointment with the cardiology provider on 09/13/21 at 2:00pm.

Review of Resident #1's cardiology provider after visit summary dated 09/17/21 revealed:
-The resident was being seen for ischemic cardiomyopathy, atrial fibrillation, heart failure, shortness of breath, and swelling of the ankle, feet, or leg.
-The provider noted the resident's weight had increased 9 pounds since discharge from the hospital on 09/07/21 (194 pounds).
-There was an order to follow-up with the cardiology provider in 2 weeks (around 10/01/21).

Review of Resident #1's hospital discharge summary dated 09/27/21 revealed:
-The resident's date of admission to the hospital was 09/23/21 and the discharge date was 09/27/21.
-The resident was diagnosed with acute on chronic congestive heart failure.
-There was an order to follow-up with cardiology provider in 2 weeks.

Review of Resident #1's provider visit notes revealed no documentation the resident had been seen by the cardiology provider since 09/17/21.

Observation of Resident #1 on 11/12/21 at 9:05am revealed:
-The resident's lower legs and ankles had redness and swelling.
-The left ankle was swollen more than the right ankle.

Interview with Resident #1 on 11/12/21 at 9:05am

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revealed:
-He had seen the cardiology provider since his hospitalizations in September 2021 but he could not recall the day.
-He had not refused to go to any appointments to his knowledge.
-He thought it was time to go back to the cardiology provider but he did not know if he had a scheduled appointment.

Interview with the Executive Director (ED) on 11/12/21 at 1:02pm revealed:
-She thought Resident #1 missed a cardiology appointment because the resident did not want to go and the resident wanted to reschedule it but she was not sure (could not recall when).
-Resident #1's cardiology appointment was not rescheduled yet because the facility's Transporter was out on leave for two months in September 2021 and October 2021.
-The Resident Care Coordinator (RCC) was responsible for rescheduling Resident #1's cardiology appointment but the RCC had been on leave for 7 days.
-Resident #1's cardiology appointment should have been rescheduled when the previous appointment was cancelled.

Telephone interview with a patient account representative at Resident #1's cardiology provider's office on 11/12/21 at 2:06pm revealed:
-Resident #1's last visit to the cardiology provider was on 09/17/21.
-There had been no other cardiology appointments scheduled for Resident #1.

Attempted telephone interview with Resident #1's cardiology provider on 11/12/21 at 2:10pm was unsuccessful.

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c. Review of Resident #1's hospital discharge summary and discharge instructions dated 09/07/21 revealed:
-The resident's date of admission to the hospital was 08/31/21 and the discharge date was 09/07/21.
-The resident presented to the emergency room (ER) with shortness of breath and leg swelling.
-The resident's discharge diagnoses included acute on chronic systolic congestive heart failure, atrial fibrillation, congestive heart failure exacerbation, shortness of breath, leg swelling, anemia, cellulitis, stage 3 chronic kidney disease, ischemic cardiomyopathy, and hypomagnesemia.
-The resident had anemia and was to follow-up with the primary care provider (PCP) in 4 to 7 days to repeat a complete blood count (CBC). (CBC is used to help provide information related to disease associated with blood cells such as anemia.)
-The resident was to have a basal metabolic panel (BMP) lab drawn by 09/13/21. (BMP is used to check several body functions including electrolytes and kidney function.)

Review of Resident #1's cardiology provider after visit summary dated 09/17/21 revealed there was an order that the resident needed a BMP lab on Wednesday, 09/22/21.

Review of Resident #1's hospital discharge summary dated 09/27/21 revealed:
-The resident's date of admission to the hospital was 09/23/21 and the discharge date was 09/27/21.
-The resident was diagnosed with acute on chronic congestive heart failure.
-There was an order for a repeat BMP level in 1 week.

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D 273	Continued From page 26 Review of Resident #1's provider visit notes and labwork revealed no documentation of a CBC or BMP being done as ordered. Review of Resident #1's record revealed no progress notes were documented for the resident since admission on 07/07/21. Interview with Resident #1 on 11/12/21 at 9:05am revealed he was not sure if he had any labwork completed since his hospitalizations in September 2021. Interview with the Executive Director (ED) on 11/12/21 at 1:02pm revealed: -She did not know if Resident #1's BMP or CBC had been checked as ordered. -The Resident Care Coordinator (RCC) or Health and Wellness Director (HWD) were responsible for coordinating with the provider to get labwork completed. -The RCC had been on leave for the last 7 days. -The HWD position had been vacant since July 2021 and a new HWD had been hired and started this week but she was in orientation. -It the absence of the RCC and the HWD, it would be her responsibility to coordinate labwork with the provider. -She had not received any lab results for Resident #1 so she would follow-up with the PCP. Telephone interview with Resident #1's PCP on 11/12/21 at 5:16pm revealed: -Resident #1 discharged from the hospital on 09/07/21 and again on 09/27/21 due to exacerbation of congestive heart failure. -The BMP lab was important because the results would give an idea of how the resident's heart was doing and the amount of fluid on the resident.	D 273		

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D 273	Continued From page 27 Attempted telephone interview with Resident #1's cardiology provider on 11/12/21 at 2:10pm was unsuccessful. 2. Review of Resident #2's current FL-2 dated 09/15/21 revealed: -Diagnoses included diabetes mellitus. -Current medications were referenced to a recent hospital discharge summary dated 09/16/21. Review of Resident #2's hospital discharge medications dated 09/16/21 revealed: -An order for Humalog insulin to be injected subcutaneously two times a day. (Humalog is a fast-acting insulin analog used to reduced blood glucose levels.) -A sliding scale per "facility formula" was ordered to be used twice a day. Review of Resident #2's physician order dated 06/10/21 revealed an order to administer 1 unit insulin for glucose levels of 170-190, administer 2 units of insulin for glucose levels of 191-200, administer 3 units of insulin for glucose levels of 201-220, administer 4 units of insulin for glucose levels of 221 or greater, and to notify the physician of glucose level higher than 300. Review of Resident #2's electronic medication administration record (eMAR) from September 2021-November 2021 revealed: -There was an entry to administer 1 unit of Humalog insulin for blood glucose levels of 170-190, administer 2 units of Humalog insulin for blood glucose levels of 191-200, administer 3 units of Humalog insulin for blood glucose levels of 201-220, administer 4 units of Humalog insulin for blood glucose levels of 221 or greater. -From 10/01/21 to 10/31/21, a total of 7 out of 62	D 273		

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times, blood glucose levels between 301 and 445 were documented.
-From 09/01/221 to 09/30/21, a total of 4 out 60 times, blood glucose levels between 309 and 409 were documented.
-There was no documentation any of the glucose levels above 300 were reported to the PCP.

Interview with a medication aide (MA) on 11/12/21 at 10:20am revealed:
-The resident independently checked her blood glucose level twice daily morning and evenings.
-She recorded the results of the blood glucose level in the resident's eMAR.
-She had never called the resident's primary care provider (PCP) to notify him of a blood glucose level of 300 or higher in the past six months.
-The order in the eMAR did not state to notify the PCP if blood glucose levels blood glucose level was 300 or higher.

Interview with Resident #2 on 11/12/21 at 10:30am revealed:
-She completed her finger stick blood sugar (FSBS) independently.
-She reported the results to the MA twice daily morning and evening.
-She was not aware if any of the MAs had reported her blood glucose levels of 300 or higher to her PCP.
-She was aware the SSI order indicated for the PCP to be notified of a blood glucose level of 300 or higher.
-The resident expected the MA to report the results to her PCP as ordered.

Review of Resident #2's personal daily log revealed:
-The resident documented the SSI parameters on the first page of the log.

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-The insulin dose parameters instructed to administer 1 unit of Humalog insulin for blood glucose levels of 170-190, administer 2 units of Humalog insulin for blood glucose levels of 191-200, administer 3 units of Humalog insulin for blood glucose levels of 201-220, administer 4 units of Humalog insulin for blood glucose levels of 221 or greater.
-There was documentation to notify the PCP of blood glucose levels of 300 or higher was documented below the insulin dose parameters.

Telephone interview with Resident #2's PCP on 11/12/21 at 12:15 revealed:
-The resident was last seen by the PCP in July 2021.
-The last order for an SSI for Humalog was written on 06/10/21.
-The order stated to notify the PCP for blood glucose levels of 300 or higher.
-The PCP's office had not been notified of the resident's blood glucose being 300 or higher in the past six months.
-The facility was expected to notify his office when the resident's blood glucose level was 300 or higher.
-Elevated blood glucose levels above 300 increased the resident's risk of extreme thirst, fatigue, blurred vision, unconsciousness, kidney damage or nerve damage.

Telephone interview with the pharmacist on 11/12/21 on 1:08pm revealed:
-The SSI parameters on file were dated for 06/10/21 from the resident's PCP.
-She was not aware the eMAR did not instruct to notify the PCP for blood glucose levels of 300 or higher.

Interview with Executive Director (ED) on

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D 273	Continued From page 30 11/12/21 at 4:04pm revealed: -The SSI in the resident's records dated 06/10/21 was the SSI used for the current Humalog order. -She was not aware the eMAR did not have documentation to notify the PCP of blood glucose levels of 300 or higher. -She was not aware the resident had a history of blood glucose levels 300 or higher. -The Resident Care Coordinator (RCC) was responsible for verifying the eMAR orders match the PCP's orders. -She expected the RCC to verify the order on the eMAR within 48 hours of pharmacy receipt of the order. -She was responsible to verify the eMAR and orders when the RCC was not available. -She was concerned about the adverse effects of a resident's blood glucose of 300 or higher and staff not notifying the PCP. The facility failed to ensure the acute and routine health care needs were met for 2 of 5 sampled residents including not notifying the provider of weight gain as ordered for Resident #1 who had been hospitalized from 08/31/21 - 09/07/21 for fluid overload and exacerbation of congestive heart failure (CHF) resulting in a second hospitalization for exacerbation of CHF from 09/23/21 - 09/27/21 and the facility failed to schedule a follow-up appointment with Resident #1's cardiology provider. The facility failed to notify Resident #2's primary care provider of the resident's blood glucose level of 300 or higher placing the resident at an increased risk for extreme fatigue, blurred vision, unconsciousness, kidney damage or nerve damage. The facility's failure resulted in substantial risk of serious physical harm and serious neglect and constitutes an Unabated Type A2 Violation.	D 273		

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D 273	Continued From page 31 The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/16/21 for this violation.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure the implementation of physician's orders for 1 of 5 sampled residents (#1) regarding orders for a fluid restriction and daily weights with parameters after the resident was hospitalized with fluid overload and exacerbation of congestive heart failure. The findings are: Review of Resident #1's current FL-2 dated 09/27/21 revealed: -Diagnoses included acute on chronic systolic congestive heart failure, acute renal failure, atrial fibrillation, and coronary artery disease. -There was a note to see discharge summary for orders. a. Review of Resident #1's hospital discharge	D 276		

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summary and discharge instructions dated 09/07/21 revealed:
-The resident's date of admission to the hospital was 08/31/21 and the discharge date was 09/07/21.
-The resident presented to the emergency room (ER) with shortness of breath and leg swelling.
-The resident reported having shortness of breath for 2 weeks and he could not walk to the door without getting short of breath.
-The resident noted he had bilateral lower extremity leg swelling for years but there had recently been new onset leg weeping and redness in the past few weeks.
-Emergency Medical Services (EMS) noted the resident had diminished left lower lung sounds on arrival, noticed weeping legs, and the resident was in atrial fibrillation.
-The hospital provider initiated fluid restrictions at the hospital.
-The resident's discharge diagnoses included acute on chronic systolic congestive heart failure, atrial fibrillation, congestive heart failure exacerbation, shortness of breath, leg swelling, anemia, cellulitis, stage 3 chronic kidney disease, ischemic cardiomyopathy, and hypomagnesemia.
-The resident was to be on a 1200ml a day fluid restriction.
-There was a second entry noting 48 - 64 ounce fluid limit per day.

Review of Resident #1's cardiology provider after visit summary dated 09/17/21 revealed:
-The resident was being seen for ischemic cardiomyopathy, atrial fibrillation, heart failure, shortness of breath, and swelling of the ankle, feet, or leg.
-The provider noted the resident's weight had increased 9 pounds since discharge from the hospital on 09/07/21 (194 pounds).

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-The resident weighed 203 pounds and 7.8 ounces at the cardiology office on 09/17/21.
-There was an order for fluid limit of 48 - 64 ounces daily.

Review of Resident #1's September 2021 electronic medication administration record (eMAR) revealed there was no entry for fluid restriction for the resident.

Review of Resident #1's hospital discharge summary dated 09/27/21 revealed:
-The resident's date of admission to the hospital was 09/23/21 and the discharge date was 09/27/21.
-The resident was diagnosed with acute on chronic congestive heart failure.

Review of Resident #1's October 2021 eMAR revealed:
-There was documentation of a 3-pound weight gain from 10/07/21 to 10/08/21; and a 9-pound weight gain from 10/22/21 to 10/27/21.
-There was no entry for documentation of fluid restriction for the resident.

Review of Resident #1's November 2021 eMAR revealed:
-There was documentation of a 7-pound weight gain from 11/05/21 to 11/08/21; and a 3-pound weight gain from 11/08/21 to 11/10/21.
-There was no entry for documentation of fluid restriction for the resident.

Interview with Resident #1 on 11/09/21 at 10:54am revealed:
-He went to the hospital twice about a month ago or more to "get fluid off" of his body.
-He stayed at the hospital about a week, came back to the facility, and then went back to the

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hospital about 2 days later.

Observation of Resident #1 on 11/10/21 from 8:28am - 8:57am revealed:
-The resident was served 1 cup of coffee, 1 cup of cranberry juice.
-The resident drank all of the coffee and the cranberry juice.

Observation of Resident #1 on 11/12/21 at 9:05am revealed:
-The resident's lower legs and ankles had redness and swelling.
-The left ankle was swollen more than the right ankle.

Interview with the Dietary Manager on 11/12/21 at 12:32pm revealed:
-The facility's water cups were 8 ounces.
-The facility's tea glasses were 8 ounces.
-The facility's coffee cups were 8 ounces.
-The white cups used for the juices were 6 ounces.
-She was not aware of any residents currently being on a fluid restriction.
-She was not aware Resident #1 had an order for a fluid restriction.
-Resident #1 usually received coffee and juice for breakfast; tea and sometimes juice for lunch; and juice, tea, water or milk for supper if he wanted it.

Interview with Resident #1 on 11/12/21 at 9:05am revealed:
-The provider at the hospital told him he could drink too much fluid.
-This morning, 11/12/21, he drank 3 cups of coffee, a cup of orange juice, and a cup of cranberry juice (a total of 36 ounces of fluids).
-He usually drank at least 2 cups of coffee (8 ounces each = 16 ounces) and a cup of cranberry

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juice (6 ounces) every day for breakfast (a total of 22 ounces of fluids with breakfast).
-He usually drank 2 glasses of unsweetened tea (8 ounces each) at lunch (a total of 16 ounces fluids).
-He usually drank 2 glasses of unsweetened tea at supper (8 ounces each) and a cup of cranberry juice (6 ounces) at supper (a total of 22 ounces of fluids).
-During the day, he kept orangeade soda (16 ounces) in his room and drank about ½ bottle (8 ounces).
-He also drank two 8-ounce bottles of water each day (total of 16 ounces).
-He also drank some water (5 ounces each time) at least twice a day when he got his medications.
-On average, he drank approximately 94 ounces (2,820mls) of fluids daily.
-He got up a lot during the night to urinate, filling up a plastic urinal and a 32-ounce cup with urine during the night.
-The facility staff had never told him to restrict his fluids and no one had ever checked on him to see how much he was drinking.
-It was not unusual for his legs, ankles, and feet to be swollen.

Interview with a medication aide (MA) on 11/12/21 at 12:22pm revealed:
-She was not aware of an order for a fluid restriction for Resident #1.
-There was no fluid restriction listed on the eMAR.
-She was not sure how much fluid Resident #1 drank each day.
-She usually gave the resident about 5 ounces of water with his medications and he usually drank all of it.
-The resident's urinal was usually filled to the top with urine each morning and sometimes the

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resident says he had dumped the urinal and filled it up again during the night.
-The Resident Care Coordinator (RCC) or the Executive Director (ED) usually processed new orders, including new FL-2s and hospital discharge summaries.
-The RCC was currently on leave and unavailable for interview.

Interview with the Executive Director (ED) on 11/12/21 at 1:02pm revealed:
-She was not aware of the order for Resident #1's fluid restriction in September 2021.
-Resident #1's provider should have been contacted about the fluid restriction order.
-The facility did not do fluid restrictions to her knowledge since it was assisted living.

Telephone interview with Resident #1's primary care provider (PCP) on 11/12/21 at 5:16pm revealed:
-Resident #1 was admitted to the hospital on 08/31/21 and again on 09/23/21 due to exacerbation of congestive heart failure.
-Not implementing the fluid restriction orders from the hospital provider on 09/07/21 and the cardiology provider on 09/17/21 could have "definitely" contributed to the resident's hospitalization for congestive heart failure on 09/23/21.
-She expected the facility to follow physician's orders.
-No one from the facility contacted her regarding the order for the fluid restriction for Resident #1.
-If the facility could not provide the fluid restriction, they should have contacted her or the cardiology provider for further instructions.

Attempted telephone interview with Resident #1's cardiology provider on 11/12/21 at 2:10pm was

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D 276	Continued From page 37 unsuccessful. b. Review of Resident #1' verbal order dated 07/28/21 revealed an order to check weight 3 times a week. Review of Resident #1's hospital discharge summary and discharge instructions dated 09/07/21 revealed: -The resident was admitted to the hospital on 08/31/21 and discharged on 09/07/21. -The resident's discharge diagnoses included acute on chronic systolic congestive heart failure, atrial fibrillation, congestive heart failure exacerbation, shortness of breath, leg swelling, anemia, cellulitis, stage 3 chronic kidney disease, ischemic cardiomyopathy, and hypomagnesemia. -The resident was to be weighed daily in the morning and record. -Report to cardiology provider: weight increase of 2 to 3 pounds overnight or 3 to 5 pounds over one week; swelling in the feet, legs, or stomach area; and increased shortness of breath with minimal activity or at rest. Review of Resident #1's cardiology provider after visit summary dated 09/17/21 revealed: -The resident was being seen for ischemic cardiomyopathy, atrial fibrillation, heart failure, shortness of breath, and swelling of the ankle, feet, or leg. -The provider noted the resident's weight had increased 9 pounds since discharge from the hospital on 09/07/21 (194 pounds). -The resident weighed 203 pounds and 7.8 ounces at the cardiology office on 09/17/21. -There was an order to record daily weights first thing in the morning, after resident voids, in same undergarments.	D 276		

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Review of Resident #1's hospital discharge summary dated 09/27/21 revealed:
-The resident's date of admission to the hospital was 09/23/21 and the discharge date was 09/27/21.
-The resident was diagnosed with acute on chronic congestive heart failure.

Review of Resident #1's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for weight check every week on Monday, Wednesday, and Friday at 8:00am.
-There were 6 weights documented from 09/01/21 - 09/30/21.
-The resident weighed 209 pounds on Wednesday, 09/15/21; 199.2 pounds on Sunday, 09/19/21; 202 pounds on Monday, 09/20/21; 197 pounds on Wednesday, 09/22/21; 199 pounds on Thursday, 09/23/21; and 196 pounds on Wednesday, 09/29/21.
-There was no documentation of the 2.8-pound weight gain from 09/19/21 to 09/20/21 being reported to the provider as ordered.
-There was no entry for the resident's weight to be checked daily.

Review of Resident #1's October 2021 eMAR revealed:
-There was an entry for weight check every week on Monday, Wednesday, and Friday at 8:00am.
-There were 11 weights documented from 10/01/21 - 10/31/21.
-The resident weighed 196 pounds on Friday, 10/01/21; 184 pounds on Monday, 10/04/21; 185 pounds on Wednesday, 10/06/21; 182 pounds on Thursday 10/07/21; 185 pounds on Friday, 10/08/21; 179 pounds on Wednesday, 10/13/21; 180 pounds on Friday, 10/15/21; 181.6 pounds on Wednesday, 10/20/21; 179 pounds on Friday,

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10/22/21; 188 pounds on Wednesday, 10/27/21; and 176 pounds on 10/29/21.
-There was no documentation of the 3-pound weight gain from 10/07/21 to 10/08/21; and the 9-pound weight gain from 10/22/21 to 10/27/21 being reported to the provider as ordered.
-There was no entry for the resident's weight to be checked daily.

Review of Resident #1's November 2021 eMAR revealed:
-There was an entry for weight check every week on Monday, Wednesday, and Friday at 8:00am.
-There were 5 weights documented from 11/01/21 - 11/10/21.
-The resident weighed 188 pounds on Monday, 11/01/21; 181 pounds on Wednesday, 11/03/21 and Friday, 11/05/21; 188 pounds on Monday, 11/08/21; and 191 pounds on Wednesday 11/10/21.
-There was no documentation of the 7-pound weight gain from 11/05/21 to 11/08/21; and the 3-pound weight gain from 11/08/21 to 11/10/21 being reported to the provider as ordered.
-There was no entry for the resident's weight to be checked daily.

Interview with Resident #1 on 11/09/21 at 10:54am revealed:
-He went to the hospital twice about a month ago or more to "get fluid off" of his body.
-He stayed at the hospital about a week, came back to the facility, and then went back to the hospital about 2 days later.

Observation of Resident #1 on 11/12/21 at 9:05am revealed:
-The resident's lower legs and ankles had redness and swelling.
-The left ankle was swollen more than the right

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D 276	Continued From page 40 ankle. Interview with Resident #1 on 11/12/21 at 9:05am revealed: -The facility staff did not weigh him or offer to weigh him. -He weighed himself on his bathroom scales every day and he would report the weights to the MAs when they asked him his weight (not sure how often). -He was supposed to weigh first thing in the morning but he usually ate breakfast before he weighed himself. -It was not unusual for his legs, ankles, and feet to be swollen. Review of Resident #1's weight chart dated 10/08/21 - 11/12/21 in the resident's room revealed: -The resident was taking and documenting his own weight daily. -The first documented weight was 180.8 pounds on 10/08/21 and the most current documented weight was 184 pounds on 11/12/21. -There were no weights documented from 10/15/21 - 10/16/21. -There was a 2.5-pound increase overnight from 10/18/21 (179.2 pounds) to 10/19/21 (182.7 pounds). -There was a 3-pound increase overnight from 11/01/21 (177 pounds) to 11/02/21 (180 pounds). -There was a 2-pound increase overnight from 11/05/21 (181 pounds) to 11/06/21 (183 pounds). -There was a 3-pound increase overnight from 11/06/21 (183 pounds) to 11/07/21 (186 pounds). -There was a 2-pound increase overnight from 11/07/21 (186 pounds) to 11/08/21 (188 pounds). -There was a 4-pound increase overnight from 11/09/21 (187 pounds) to 11/10/21 (191 pounds).	D 276		

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D 276	Continued From page 41 Interview with a medication aide (MA) on 11/12/21 at 12:22pm revealed: -Resident #1 had scales in his bathroom that the resident used to weigh himself. -The MAs had used the facility scales in the past to weight the resident but the resident wanted to weigh early in the morning so he used his own scales. -If the resident had already weighed himself, the MAs just documented what the resident told them he weighed. -The resident's weight was only documented 3 times a week because that was how it was listed on the eMAR. -She was not aware of any weight parameters and none were listed on the eMAR. -The Resident Care Coordinator (RCC) or the Executive Director (ED) usually processed new orders, including new FL-2s and hospital discharge summaries. -The RCC was currently on leave and unavailable for interview. Interview with the Executive Director (ED) on 11/12/21 at 1:02pm revealed: -Resident #1's weights should be checked daily and documented as ordered. -The MAs should use the facility's scales to weigh the resident to ensure accuracy of the weights. -New FL-2s and hospital discharge summaries should be faxed to the pharmacy. -The pharmacy staff as responsible for entering orders into the eMAR system. -The orders had to be verified in the eMAR system by facility staff prior to the order becoming active on the eMAR. -The ED, RCC, Health and Wellness Director (HWD), or the MAs had access to verify orders in the eMAR system.	D 276		

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D 276	Continued From page 42 Telephone interview with Resident #1's primary care provider (PCP) on 11/12/21 at 5:16pm revealed: -Resident #1 discharged from the hospital on 09/07/21 and again on 09/27/21 due to exacerbation of congestive heart failure. -She expected the facility to follow physician's orders and check the resident's weight daily. -She only recalled the facility notifying her on 1 or 2 occasions about weight gain for the resident but she could not recall the dates. -She expected the facility to notify her of weight gains because she could take closer look at the resident to see if she needed to adjust the diuretics (for fluid retention) or if she needed to reach out to the cardiology provider to try to prevent another hospitalization. Attempted telephone interview with Resident #1's cardiology provider on 11/12/21 at 2:10pm was unsuccessful. _____ The facility failed to ensure implementation which included orders for Resident #1's fluid restriction and daily weights with parameters after the resident was hospitalized from 08/31/21 - 09/07/21 for fluid overload and exacerbation of congestive heart failure (CHF) and a second hospitalization for exacerbation of CHF from 09/23/21 - 09/27/21. The facility's failure resulted in substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/16/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 12, 2021.	D 276		

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D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 3 residents (#2, #8) observed during the medication passes evidenced by errors which included a medication to treat high blood pressure, heart failure, and to reduce the risk of death after a heart attack, a medication to reduce the risk of a heart attack, a Vitamin D supplement, and a calcium supplement (#8); a long-acting insulin to control high blood sugar, a medication to treat chest pain and heart disease, and a medication to treat skin rash (#2); and for 4 of 5 residents (#1, #2, #3, #5) sampled for record review including errors with a medication to treat congestive heart failure, a diuretic for fluid retention, and an expired insulin (#1); a sliding scale rapid-acting insulin to control high blood sugar (#2); a medication to treat a central nervous system disorder (#3), and a medication to treat depression (#5). The findings are: 1. The medication error rate was 24% as	D 358		

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evidenced by the observation of 7 errors out of 29 opportunities during the 8:00am medication pass on 11/10/21.

a. Review of Resident #8's current FL-2 dated 09/16/21 revealed:
-Diagnoses included dementia, hypertension, hypoxia, altered mental status, hyponatremia, and possible bacteremia.
-There was a notation on the medication section to see hospital discharge summary.

Review of Resident #8's signed hospital discharge summary and medication report dated 09/16/21 revealed:
-She was admitted to the hospital on 09/13/21 for hypoxia (decreased oxygen to body tissues that can cause organ damage or death) and an elevated Troponin level (an indication of damage to the heart or a heart attack).
-She was discharged from the hospital and returned to the facility on 09/16/21 with medication orders.
-There was an order for Metoprolol Succinate 25mg 1 tablet daily to start 09/17/21. (Metoprolol is used to treat high blood pressure and heart failure and may lower the risk of death after a heart attack.)
-There was an order for Aspirin 81mg 1 tablet daily to start 09/17/21. (Aspirin is used to reduce the risk of a heart attack.)
-There was an order change in dose and strength for Calcium Carbonate 600mg 1 tablet daily to start on 09/17/21. (Calcium Carbonate is used for heart health and as an antacid to relieve heartburn and indigestion.)

Observation of Resident #8's 8:00am medication pass on 11/10/21 revealed:
-The medication aide (MA) prepared and

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administered medications to Resident #8 at 8:38am.
-Metoprolol Succinate 25mg 1 tablet daily was not offered or administered to the resident when she received her other medications.
-Aspirin 81mg 1 tablet daily was not offered or administered to the resident when she received her other medications.
-The incorrect dose of Calcium Carbonate 600mg 2 tablets daily was administered to the resident when she received her other medications.

Review of Resident #8's September 2021 electronic administration record (MAR) revealed:
-There was no entry for Metoprolol Succinate 25mg 1 tablet daily.
-There was no entry for Aspirin 81mg 1 tablet daily.
-There was no entry for Calcium Carbonate 600mg 1 tablet daily.
-There was an entry for Calcium Carbonate 600 mg 2 tablets (1200 mg) daily scheduled at 8:00am.

Review of Resident #8's October 2021 eMAR revealed:
-There was no entry for Metoprolol Succinate 25mg 1 tablet daily.
-There was no entry for Aspirin 81mg 1 tablet daily.
-There was no entry for Calcium Carbonate 600mg 1 tablet daily.
-There was an entry for Calcium Carbonate 600mg 2 tablets (1200mg) daily scheduled at 8:00am.

Review of Resident #8's eMAR from November 1, 2021 through November 10, 2021 revealed:
-There was no entry for Metoprolol Succinate 25mg 1 tablet daily.

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D 358	Continued From page 46 -There was no entry for Aspirin 81mg 1 tablet daily. -There was no entry for Calcium Carbonate 600mg 1 tablet daily. -There was an entry for Calcium Carbonate for 600mg 2 tablets (1200mg) daily scheduled at 8:00am Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/10/21 at 4:30pm revealed: -The pharmacy did not receive Resident #8's FL-2/hospital discharge summary dated 09/16/21 with orders for Metoprolol Succinate 25mg 1 tablet daily, Aspirin 81mg 1 tablet daily, and a change for Calcium Carbonate 600mg 1 tablet daily to start on 09/17/21. -These medications were not filled and dispensed by the pharmacy because the orders were not received from the facility. -The most current order on file for the resident's Calcium Carbonate was 600mg 2 tablets (1200mg) daily dated 02/06/19. Interview with the MA in the special care unit (SCU) on 11/10/21 at 12:10pm revealed: -There was no entry on the eMAR for Resident #8 to receive Metoprolol Succinate 25mg 1 tablet daily at 8:00am. -There was no entry on the eMAR for Resident #8 to receive Aspirin 81mg 1 tablet daily at 8:00am. -There was an entry for Calcium Carbonate 600mg 2 tablets (1200mg) daily at 8:00am. -The eMAR did not have an entry for Calcium Carbonate 600mg 1 tablet daily at 8:00am. -The Resident Care Coordinator (RCC) was responsible for transcribing medication orders and ensuring orders were faxed to the pharmacy. -The facility did not have an RCC currently. -There had not been a medication cart audit in a	D 358		

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while to ensure medications were in the cart.
-She could not remember that last time a medication audit was done.

Interview with the Executive Director (ED) on 11/10/21 at 10:30am revealed:
-It was the responsibility of the RCC or the Health and Wellness Director (HWD) to review medication orders and electronically fax them to the pharmacy to be filled and entered on the eMAR.
-If the RCC and HWD were not available, it was her responsibility to ensure medication orders were electronically faxed to pharmacy.
-She did not fax the orders to pharmacy because they were overlooked.
-If a medication order was received after hours on a weekday or on the weekend, the MAs were responsible for faxing the order to the pharmacy.
-Medication cart audits should be done weekly by the RCC to ensure ordered medications are in the cart.
-She could not remember the last time a medication cart audit was done.
-She did not know why the medications ordered on the hospital discharge summary of Resident #8 on 09/16/21, which included Metoprolol Succinate 25mg, Aspirin 81mg, and a change for Calcium Carbonate 600mg dosage, were not faxed to the pharmacy.

Telephone interview with Resident #8's power of attorney (POA)/family member on 11/12/21 at 10:30am revealed:
-Resident #8 was transported to the hospital between 8:00am and 9:00am on 09/13/21.
-The cardiologist at the hospital informed them that test results showed an elevated protein called Troponin which indicated Resident #8 might have had a heart attack.

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D 358	Continued From page 48 -Resident #8 was discharged from the hospital and returned to the facility on 09/16/21. -The family brought the hospital discharge papers and the medications, which included Metoprolol Succinate 25mg and Aspirin 81mg dispensed by the hospital pharmacy, to the facility on 09/16/21. -They did not remember who they gave the hospital discharge papers and medications to. -They were very concerned that Resident #8 did not receive the medications which included Metoprolol Succinate 25mg and Aspirin 81mg as ordered because she had suffered a heart attack two months ago. A second interview with the ED on 11/12/21 at 4:10pm revealed: -The POA/family member informed her today, 11/12/21, that they had brought the medications which included Metoprolol Succinate 25mg and Aspirin 81mg and the hospital discharge papers to the facility when Resident #8 was discharged from the hospital on 09/16/21. -She found Resident #8's medications which included Metoprolol Succinate 25mg and Aspirin 81mg on the medication cart today (11/12/21) unopened. -She was concerned that the MAs did not inform her the medications were on the medication cart or were not aware they were on the cart. -She did not know who received the medications from Resident #8's family on 09/16/21. Observation on 11/12/21 at 4:10pm revealed the hospital dispensed medications brought to the facility on 09/16/21 by Resident #8's family, which included Metoprolol Succinate 25mg and Aspirin 81mg, were sitting on the desk of the ED in her office after the medications were discovered on the medication cart.	D 358		

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D 358	Continued From page 49 Telephone interview with Resident #8's primary care provider (PCP) on 11/12/21 at 5:11pm revealed: -She saw Resident #8 on 09/13/21 at the facility and noticed she was not at her baseline (her normal). -She sent the resident to the hospital for further evaluation on 09/13/21. -Resident #8 was admitted to the hospital for hypoxia and an elevated troponin level which indicated she had a heart attack. -The ED notified her on yesterday, 11/11/21, that Resident #8 did not receive the Metoprolol Succinate 25mg, the Aspirin 81mg, and the correct dose of Calcium Carbonate 600mg 1 tablet ordered to start on 09/17/21 because the orders were not sent to the pharmacy to be filled and dispensed. -She was very concerned that the heart medications which included Metoprolol Succinate 25mg and Aspirin 81mg were not administered as ordered on 09/16/21 and could result in the Resident #8 going back to the hospital due to a heart attack or heart failure. -The change in the Calcium Carbonate 600mg 1 tablet daily was ordered by the cardiologist at the hospital who made the change for a specific reason. -She expected medications to be administered as ordered. -The facility was responsible for faxing orders to the pharmacy. b. Review of Resident #8's signed hospital discharge summary and medication report dated 09/16/21 revealed an order to continue Vitamin D3 50mcg 1 tablet daily. (Vitamin D is used for immune support and calcium absorption for bone health.)	D 358		

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D 358	Continued From page 50 Observation of Resident #8's 8:00am medication pass on 11/10/21 revealed: -Vitamin D3 50mcg was not offered or administered to the resident when she received her other medications at 8:38am. -There was no Vitamin D3 on hand in the medication cart. Review of Resident #8's September 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin D3 50mcg 1 tablet daily scheduled at 8:00am. -There was documentation that Vitamin D3 50mcg was administered daily from 09/01/21-09/30/21 except when it was documented the resident was at the hospital on 09/13/21-09/16/21. Review of Resident #8's October 2021 eMAR revealed: -There was an entry for Vitamin D3 50mcg 1 tablet daily scheduled at 8:00am. -There was documentation that Vitamin D3 50mcg was administered daily from 10/01/21-10/31/21. Review of Resident #8's eMAR from November 1, 2021 through November 10, 2021 revealed: -There was an entry for Vitamin D3 50mcg 1 tablet daily scheduled at 8:00am. -There was documentation that Vitamin D3 50mcg was administered daily from 11/01/21-11/10/21 which included the medication pass on 11/10/21, when none was on hand. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/10/21 at 4:30pm revealed the last request from the facility to refill Resident #8's Vitamin D3 was 08/28/21 for	D 358		

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a 30-day supply.

Interview with the MA in the special care unit (SCU) on 11/10/21 at 12:10pm revealed:
There was an entry for Resident #8's Vitamin D3 to be administered at 8:00am.
-There was no Vitamin D3 on hand in the medication cart to be administered at 8:00am.
-She documented that the Vitamin D3 had been administered by mistake.
-There had not been a medication cart audit in a while to ensure medications were in the cart.
-She could not remember the last time a medication cart audit was done.

Interview with the Executive Director (ED) on 11/10/21 at 4:10pm revealed:
-She did not know why Vitamin D3 50mcg was not in the cart and not administered during the 8:00 am medication pass on 11/10/21.
-Medication cart audits should be done weekly by the RCC to ensure ordered medications were in the cart.
-She expected the MAs to fax orders to pharmacy when the medication was about to run out or was not available on the cart.

Interview with Resident #8's primary care provider (PCP) on 11/12/21 at 5:11pm revealed:
-The ED notified her yesterday, 11/11/21, that Resident #8 did not receive the Vitamin D3 medication as ordered at the 8:00am medication pass on 11/10/21 because the medication was unavailable.
-The Vitamin D3 was needed for the elderly because they tend to have deficient levels of Vitamin D3.
-She expected medications to be administered as ordered.
-The facility was responsible for faxing orders to

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the pharmacy.

Attempted telephone interview with Resident #8's cardiologist on 11/12/21 at 10:28am was unsuccessful.

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

c. Review of Resident #2's current FL-2 dated 09/15/21 revealed diagnoses included chronic obstructive pulmonary disease, chronic respiratory failure, type 2 diabetes, atrial fibrillation, hypertension, and congestive heart failure.

Review of Resident #2's hospital discharge summary and medication report dated 09/16/21 revealed there was an order for Levemir insulin inject 26 units daily. (Levemir is used to control high blood sugar).

Observation of the 8:00am medication pass on 11/10/21 revealed Resident #2 was administered 30 units of Levemir at 8:11am instead of the 26 units as ordered.

Review of Resident #2's electronic medication administration record (eMAR) from November 1, 2021 through November 10, 2021 revealed:
-There was an entry for Levemir insulin inject 30 units every morning at 8:00am.
- Levemir insulin 30 units was documented as administered from 11/01/21-11/10/21 at 8:00am.
-Resident #2's blood sugars ranged from 83-170 from 11/01/21-11/10/21 at 8:00am which included a blood sugar of 127 on 11/10/21 at the 8:00am medication pass.

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D 358	Continued From page 53 Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/12/21 at 1:04pm revealed: -The last order on file for Levemir insulin dated 07/28/21 was for 30 units. -The pharmacy did not receive a hospital discharge medication order for Levemir 26 units dated 09/16/21. Interview with the medication aide (MA) on 11/10/21 at 12:15pm revealed. -She administered Resident #2's medication based on the entry in the eMAR, Levemir 30 units at 8:00am. -The resident had received Levemir insulin 30 units for a while. -She did not know how long the resident had been receiving Levemir 30 units daily. Interview with Resident #2 on 11/12/21 at 4:04pm revealed she had been getting 30 units of the Levemir insulin at 8:00am. Interview with the Executive Director (ED) on 11/12/21 at 5:10pm revealed: -She was not aware Resident #2's Levemir insulin had been changed on a hospital discharge summary report and medication order dated 09/16/21. -She did not know why the order on 09/16/21 for Levemir insulin 26 units for the resident was not faxed to pharmacy. Interview with Resident #2's primary care provider (PCP) on 11/12/21 at 4:00pm revealed he was not aware the resident's Levemir insulin had been changed from 30 units to 26 units on the 09/16/21 hospital discharge summary and medication report.	D 358		

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d. Review of Resident #2's hospital discharge summary and medication report dated 09/16/21 revealed there was an order for Isosorbide Mononitrate 30mg ER by mouth every morning. (Isosorbide Mononitrate is an extended release medication used to treat chest pain in people with coronary artery disease, a narrowing of blood vessels that supply blood to the heart.)

Observation of the 8:00am medication pass on 11/10/21 revealed Resident #2 was not offered or administered the Isosorbide Mononitrate ER 30mg as ordered when she received her other medications at 8:09am.

Review of Resident #2's electronic medication administration record (eMAR) from November 1, 2021 through November 10, 2021 revealed:
-There was an entry for Isosorbide Mononitrate ER 30mg at 8:00am documented as administered from 11/01/21 - 11/09/21.
-The Isosorbide Mononitrate ER 30mg was not documented as administered at 8:00am on 11/10/21 because it was "not available."

Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/12/21 at 1:04pm revealed the last request from the facility for Resident #2's Isosorbide Mononitrate ER 30mg was on 10/11/21 for a 30-day supply.

Interview with Resident #2 on 11/12/21 at 4:04pm revealed she did not experience any chest pains.

Interview with the medication aide (MA) on 11/10/21 at 12:15pm revealed
-The entry in the eMAR was Isosorbide Mononitrate ER 30mg 1 tablet at 8:00am.
-She did not offer or administered the Isosorbide Mononitrate to Resident #2 because it was not on

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hand in the medication cart.
-She was going to contact the pharmacy to request a refill of the Isosorbide Mononitrate after completing the morning medication pass on 11/10/21.

Interview with the Executive Director (ED) on 11/12/21 at 5:10pm revealed:
-She did not know why the Isosorbide Mononitrate for Resident #2 was not on hand in the medication cart.
-The MAs were responsible for faxing refill orders to the pharmacy when the medication was running low or not available on the medication cart.

Interview with Resident #2's primary care provider (PCP) on 11/12/21 at 4:00pm revealed he was not concerned the resident missed one dose of the Isosorbide Mononitrate.

e. Review of Resident #2's hospital discharge summary and medication report dated 09/16/21 revealed an order for Nystatin-Triamcinolone cream apply topically 2 times a day. (Nystatin-Triamcinolone is used to treat skin rash and irritation).

Observation of the 8:00am medication pass on 11/10/21 revealed Resident #2 was not offered or administered the Nystatin-Triamcinolone cream as ordered when she received her other medications at 8:09am.

Review of Resident #2's October 2021 electronic medication administration record (eMAR) revealed Nystatin-Triamcinolone cream was documented as administered every day from 10/01/21 to 10/31/21 at 8:00am and 8:00pm.

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D 358	Continued From page 56 Review of Resident #2's eMAR from November 1, 2021 through November 10, 2021 revealed: -There was an entry for Nystatin-Triamcinolone External Cream spread topically to affected areas twice a day at 8:00am and 8:00pm. -Nystatin-Triamcinolone Cream was documented as administered from 11/01/21 - 11/09/21 at 8:00am. -The Nystatin-Triamcinolone Cream was documented as not administered on 11/10/21 during the 8:00am medication pass because the medication was not in the medication cart. Interview with the medication aide (MA) on 11/10/21 at 12:15pm revealed. -She did not offer the Nystatin-Triamcinolone Cream to Resident #2 because she knew it was not in the medication cart because she had worked on that cart the night before. -The resident had refused the Nystatin-Triamcinolone Cream more than three times. -It was a facility policy that if a resident refused a medication more than three times they could contact the primary care provider (PCP) to see if she/he wanted to discontinue the medication. -She had not contacted the PCP to request an order to discontinue the Nystatin-Triamcinolone Cream. Interview with Resident #2 on 11/12/21 at 3:00pm revealed: -She was prescribed Nystatin-Triamcinolone Cream when she was discharged from the hospital on 09/16/21 because she developed vaginosis due to antibiotics she received during her stay. -She used the cream until about the end of September 2021. -She had not used the cream since September	D 358		

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2021.
-She initially had 2 tubes of the cream; she used one whole tube and had the other tube stored in her room if she needed it in the future.
-She had told the MAs multiple times that she was no longer using the cream.
-She did not use the cream in October or November.
-She produced a tube labeled as Nystatin-Triamcinolone from her bathroom.

Interview with the Executive Director (ED) on 11/12/21 at 4:10pm revealed:
-She did not know why the Nystatin-Triamcinolone Cream was not on hand on the medication cart.
-She expected the MAs to place a refill order with the pharmacy when a medication was about to run out or not on hand in the medication cart.

2. Review of Resident #1's FL-2 dated 09/27/21 revealed diagnoses included acute on chronic systolic congestive heart failure, acute renal failure, atrial fibrillation, and coronary artery disease.

a. Review of Resident #1's FL-2 dated 09/07/21 revealed:
-Diagnoses included acute on chronic systolic congestive heart failure, shortness of breath, stage 3 chronic kidney disease, and hypomagnesemia (low magnesium levels).
-The medication order section noted to see discharge summary for discharge medications list.

Review of Resident #1's hospital discharge summary and discharge instructions dated 09/07/21 revealed:
-The resident's date of admission to the hospital

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was 08/31/21 and the discharge date was 09/07/21.
-The resident presented to the emergency room (ER) with shortness of breath and leg swelling.
-The resident reported having shortness of breath for 2 weeks and he could not walk to the door without getting short of breath.
-The resident noted he had bilateral lower extremity leg swelling for years but there had recently been new onset leg weeping in the past few weeks and redness.
-Emergency Medical Services (EMS) noted the resident had diminished left lower lung sounds on arrival, noticed weeping legs, and the resident was in atrial fibrillation.
-The resident's discharge diagnoses included acute on chronic systolic congestive heart failure, atrial fibrillation, congestive heart failure exacerbation, shortness of breath, leg swelling, anemia, cellulitis, stage 3 chronic kidney disease, ischemic cardiomyopathy, and hypomagnesemia.
-There was an order for Entresto 49-51mg take 1 tablet two times a day. (Entresto is used for the treatment of symptomatic chronic heart failure, decreases the build up of sodium and fluid in the body, and decreases the risk for hospitalization and death related to heart failure.)

Review of Resident #1's prescription dated 09/07/21 revealed an order for Entresto 49-51mg 1 tablet two times a day for 60 tablets and no refills by the hospital provider.

Review of Resident #1's cardiology provider after visit summary dated 09/17/21 revealed:
-The resident was being seen for ischemic cardiomyopathy, atrial fibrillation, heart failure, shortness of breath, and swelling of the ankle, feet, or leg.
-The provider noted the resident's weight had

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increased 9 pounds since discharge from the hospital on 09/07/21 (194 pounds).
-The resident weighed 203 pounds and 7.8 ounces at the cardiology office on 09/17/21.

Review of Resident #1's hospital discharge summary dated 09/27/21 revealed:
-The resident's date of admission to the hospital was 09/23/21 and the discharge date was 09/27/21.
-The resident was diagnosed with acute on chronic congestive heart failure.
-There was an order for Entresto 49-51mg take 1 tablet two times a day.

Review of Resident #1's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Entresto 49-51mg 1 tablet twice a day scheduled for 8:00am and 8:00pm.
-Documentation for the administration of Entresto started at 8:00am on 09/08/21.
-Entresto was documented as not administered on 16 of 46 occasions from 09/08/21 - 09/30/21 due to the medication being unavailable and on reorder.
-The 16 occasions Entresto was documented as unavailable included: 8:00am on 09/15/21, 09/18/21, 09/21/21, and 09/30/21; and 8:00pm from 09/13/21 - 09/15/21, 09/17/21 - 09/19/21, 09/21/21 - 09/22/21, and 09/27/21 - 09/30/21.
-Entresto was not documented as administered from 8:00pm on 09/23/21 - 8:00am on 09/27/21 due to the resident being out of the facility and in the hospital.

Review of Resident #1's October 2021 eMAR revealed:
-There was an entry for Entresto 49-51mg 1

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tablet twice a day scheduled for 8:00am and 8:00pm.
-Entresto was documented as not administered on 25 of 62 occasions from 10/01/21 - 10/31/21 due to the medication being unavailable
-The 25 occasions Entresto was documented as unavailable included: 8:00am on 10/02/21 - 10/03/21 and 10/12/21; and 8:00pm from 10/01/21 - 10/03/21, 10/05/21 - 10/16/21, 10/19/21 - 10/22/21, and 10/24/21 - 10/26/21.

Review of Resident #1's November 2021 eMAR revealed:
-There was an entry for Entresto 49-51mg 1 tablet twice a day scheduled for 8:00am and 8:00pm.
-Entresto was documented as not administered at 8:00pm from 11/07/21 - 11/09/21 due to the medication being unavailable.
-There was documentation of a "courtesy fill" on 11/09/21 and Entresto was documented as administered starting at 8:00am on 11/10/21.

Observation of Resident #1's medications on hand on 11/12/21 at 11:54am revealed:
-There was a supply of 60 Entresto 49-51mg tablets dispensed on 11/09/21.
-There were 55 of 60 Entresto tablets remaining.

Interview with Resident #1 on 11/09/21 at 10:54am revealed:
-He went to the hospital twice about a month ago or more to "get fluid off" of his body.
-He stayed at the hospital about a week, came back to the facility, and then went back to the hospital about 2 days later.

Interview with a medication aide (MA) on 11/12/21 at 11:54am revealed:
-The MAs were responsible for ordering

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medications when there were 10 to 12 tablets remaining.
-The MAs reordered medications by pulling the sticker from the label and faxing the information to the pharmacy.
-The facility usually received medications that were reordered the next day.
-The facility received a courtesy fill of Entresto for the first time on 11/09/21.
-She did not know if anyone had reported the resident did not have any Entresto to the Executive Director (ED) or the primary care provider (PCP).
-She did not call the pharmacy or the PCP about the Entresto and had not explanation for not calling.
-She had no explanation for why Entresto was documented as administered on the eMAR on multiple occasions when none was available to administer.

Review of the facility's pharmacy refill/reorder request forms revealed:
-Resident #1's Entresto was listed on the refill/reorder request forms on 09/15/21, 10/10/21, and 10/13/21.
-The request form dated 09/15/21 had a fax confirmation dated 09/15/21.
-The request forms dated 10/10/21 and 10/13/21 did not have a fax confirmation but a handwritten note of "call-in" with no initials, date or time of the call in.

Review of an email from the facility's contracted pharmacy dated 11/12/21 at 2:08pm revealed:
-The pharmacy noted Resident #1's Entresto was filled on 09/07/21 and sent to the facility on 09/07/21.
-The facility sent a request to refill the Entresto on 09/15/21 but it was too soon to refill the

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medication at that time because it had just been filled on 09/07/21.
-On 09/29/21 when the medication was due to be filled, the pharmacy requested a refill from the provider.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 11/12/21 at 1:46pm revealed:
-They dispensed and sent 60 Entresto 49-51mg tablets on 09/07/21 to the facility.
-The prescription was from the hospital and had no refills.
-The pharmacy contacted the provider on the prescription (hospital provider) for a refill but did not hear back from the provider (did not know date).
-The pharmacy did a "courtesy refill" on 11/09/21 for 60 tablets of Entresto.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/12/21 at 2:01pm revealed not receiving Entresto could cause a flare up in congestive heart failure.

Interview with the ED on 11/12/21 at 1:02pm revealed:
-It appeared Resident #1 had no refills on the Entresto and no one bothered to check with the PCP to get refills.
-The MAs got a "courtesy" refill from the pharmacy way after the fact.
-The facility did not receive automatic cycle fills from the pharmacy.
-The MAs were responsible for reordering medications when there was a 7-day supply of medication remaining.
-She expected medications to be available and administered as ordered.
-Resident #1's primary care provider (PCP) was

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at the facility on Wednesday, 11/10/21, and she told the PCP about Resident #1 missing the Entresto dosages at that time.
-The PCP was not notified of the missed doses of Entresto prior to 11/10/21.
-She was concerned that Resident #1 not receiving the Entresto caused the resident's congestive heart failure to not be controlled properly.
-The MAs should have let her know Resident #1's Entresto was unavailable and the pharmacy did not send it.

Telephone interview with Resident #1's PCP on 11/12/21 at 5:16pm revealed:
-Resident #1 discharged from the hospital on 09/07/21 and again on 09/27/21 due to exacerbation of congestive heart failure.
-She was concerned that Resident #1 did not received Entresto as ordered on 09/07/21 as it probably contributed to the resident's fluid overload and exacerbation of congestive heart failure resulting in another hospitalization for the same on 09/23/21.
-She expected the facility to follow physician's orders.

Attempted telephone interview with Resident #1's cardiology provider on 11/12/21 at 2:10pm was unsuccessful.

b. Review of Resident #1's hospital discharge summary and discharge instructions dated 09/07/21 revealed:
-The resident's date of admission to the hospital was 08/31/21 and the discharge date was 09/07/21.
-The resident's discharge diagnoses included acute on chronic systolic congestive heart failure, atrial fibrillation, congestive heart failure

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exacerbation, shortness of breath, leg swelling, anemia, cellulitis, stage 3 chronic kidney disease, ischemic cardiomyopathy, and hypomagnesemia.
-There was an order for Spironolactone 25mg 1 tablet daily. (Spironolactone is a diuretic used treat fluid retention and swelling.)

Review of Resident #1's hospital discharge summary dated 09/27/21 revealed:
-The resident's date of admission to the hospital was 09/23/21 and the discharge date was 09/27/21.
-The resident was diagnosed with acute on chronic congestive heart failure.
-There was an order for Spironolactone 25mg 1 tablet daily.

Review of Resident #1's November 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Spironolactone 25mg 1 table every day at 8:00am.
-Spironolactone was not documented as administered from 11/10/21 - 11/12/21 due to the medication being unavailable.

Observation of Resident #1's medications on hand on 11/12/21 at 11:54am revealed there were no Spironolactone 25mg tablets on hand.

Interview with Resident #1 on 11/09/21 at 10:54am revealed:
-He went to the hospital twice about a month ago or more to "get fluid off" of his body.
-He stayed at the hospital about a week, came back to the facility, and then went back to the hospital about 2 days later.

Observation of Resident #1 on 11/12/21 at 9:05am revealed:

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D 358	Continued From page 65 -The resident's lower legs and ankles had some redness and swelling. -The left ankle was swollen more than the right ankle. Second interview with Resident #1 on 11/12/21 at 9:05am revealed: -He could not remember all of the medications he took. -He sometimes propped up his legs to help with the swelling. Interview with a medication aide (MA) on 11/12/21 at 11:54am revealed: -The MAs were responsible for ordering medications when there was 10 to 12 tablets remaining. -The MAs reordered medications by pulling the sticker from the label and faxing the information to the pharmacy. -The facility usually received medications that were reordered the next day. -She called the pharmacy on Wednesday, 11/10/21, about Resident #1's Spironolactone needing to be refilled. -The pharmacy staff told her that Spironolactone would be delivered in the pharmacy tote that night, 11/10/21, but it was not. -She called the pharmacy again today, 11/12/21, and was told the Spironolactone would be in the tote tonight. -She did not document any calls to the pharmacy because the facility did not document any progress notes. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 11/12/21 at 1:46pm revealed: -Resident #1's Spironolactone was dispensed once on 09/07/21 for a 30-day supply.	D 358		

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D 358	Continued From page 66 -The prescription was from the hospital and it had no refills. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/12/21 at 2:01pm revealed the resident not receiving Spironolactone as ordered could be considered concerning because the resident could retain fluid. Interview with the Executive Director (ED) on 11/12/21 at 1:02pm revealed: -The facility did not receive automatic cycle fills from the pharmacy. -The MAs were responsible for reordering medications when there was a 7-day supply of medication remaining. -She expected medications to be available and administered as ordered. -The MAs should let the ED know if a medication was unavailable and the pharmacy did not send it. -She was not aware Resident #1's Spironolactone was unavailable. -She was concerned the missed doses of the Spironolactone could cause the resident to have more fluid retention. Telephone interview with Resident #1's primary care provider (PCP) on 11/12/21 at 5:16pm revealed: -Resident #1 was admitted to the hospital on 08/31/21 and again on 09/23/21 due to exacerbation of congestive heart failure. -She expected the facility to follow physician's orders. -She saw the resident on Monday, 11/08/21, because of a weight gain. -Resident #1 needed the Spironolactone to help prevent fluid retention, which would cause weight	D 358		

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gain.
-She was concerned missed doses of Spironolactone could lead to fluid overload and exacerbation of congestive heart failure for the resident.

Attempted telephone interview with Resident #1's cardiology provider on 11/12/21 at 2:10pm was unsuccessful.

c. Review of Resident #1's hospital discharge summary dated 09/27/21 revealed an order for Lantus insulin inject 12 units nightly. (Lantus is long-acting insulin used to lower blood sugar.)

Observation of Resident #1's medications on hand on 11/12/21 at 11:54am revealed:
-There was one vial of Lantus insulin dispensed on 09/17/21.
-The handwritten open date on the auxiliary label was 10/06/21 and printed instructions to discard after 28 days.
-The manufacturer label for the Lantus instructed vials must be discarded 28 days after being opened.

Review of Resident #1's November 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Lantus insulin inject 12 units nightly at 8:00pm.
-Lantus was documented as administered nightly from 11/01/21 - 11/11/21, including 8 doses after the insulin expired on 11/03/21.
-The resident's blood sugar ranged from 78 - 163 from 11/01/21 - 11/12/21.

Interview with Resident #1 on 11/09/21 at 10:54am revealed he was administered insulin at night and his blood sugar was checked every

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D 358	Continued From page 68 morning at 5:00am. Interview with a medication aide (MA) on 11/12/21 at 5:38pm revealed: -She administered Lantus insulin to Resident #1 after it expired on 11/03/21. -She had not noticed Resident #1's Lantus insulin had expired. -The expired insulin should not have been administered. Interview with a second MA on 11/12/21 at 11:54am revealed: -The MAs were supposed to discard insulin when it expired. -Most insulins expired in 28 to 30 days from opening. -She had not noticed Resident #1's Lantus insulin was expired because she did not usually administer medications on second shift. -She could not locate any new vials of Lantus insulin on hand for Resident #1 so she would order a new vial today, 11/12/21. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 11/12/21 at 1:46pm revealed: -Resident #1's Lantus was last dispensed on 09/17/21 with one vial. -They received a new order request for the Lantus insulin today, 11/12/21. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/12/21 at 2:01pm revealed receiving expired insulin could cause an increase in blood sugar because the insulin may not be as effective. Interview with the Executive Director (ED) on 11/12/21 at 1:02pm revealed:	D 358		

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-The facility's policy was for the MAs to document the date insulin was opened on the expiration label on the insulin vials or pens.
-After insulin expired, the MAs were supposed to discard it and order a new supply of insulin.
-The MAs should check the date and not administer expired insulin.
-The MAs could call the back-up pharmacy and have a new supply of insulin sent by courier the same day.
-The MA/Supervisor was responsible for completing medication cart audits as needed when instructed by the ED.
-The RCC was responsible for doing medication cart audits by auditing 1 to 2 medication carts per week, including checking for expired medications and MARs.
-The last medication audit for the B hall (Resident #1's hall) was done on 10/21/21.
-There had been no audit on Resident #1's medications since 10/21/21 but it should have been done weekly.

Telephone interview with Resident #1's primary care provider (PCP) on 11/12/21 at 5:16pm revealed:
-The resident should not receive expired insulin because it could be less effective at controlling the resident's blood sugar.
-She expected the MAs to discard expired insulin and use refills to obtain a new vial.

3. Review of Resident #2's current FL-2 dated 09/15/21 revealed:
-Diagnoses included diabetes mellitus.
-Current medications were referenced to a recent hospital discharge summary.

Review of Resident #2's hospital discharge summary dated 09/16/21 revealed:

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D 358	Continued From page 70 -An order for Humalog insulin to be injected subcutaneously two times a day; 8:00am and 8:00pm. (Humalog is a fast-acting human insulin analog used to reduced blood glucose levels.) -A sliding scale per "facility formula" was ordered to be used twice a day. Review of Resident #2's physician order date 06/10/21 revealed an order stated to administer 1 unit of Humalog insulin for blood glucose levels of 170-190, administer 2 units of Humalog insulin for blood glucose levels of 191-200, administer 3 units of Humalog insulin for blood glucose levels of 201-220, administer 4 units of Humalog insulin for blood glucose levels of 221 or greater, and to notify the physician of blood glucose level higher than 300. Review of Resident #2's September 2021 electronic medication administration record (eMAR) revealed: -There was an entry for 1 unit of Humalog insulin for blood glucose levels of 170-190, administer 2 units of Humalog insulin for blood glucose levels of 191-200, administer 3 units of Humalog insulin for blood glucose levels of 201-220, and administer 4 units of Humalog insulin for blood glucose levels of 221 or greater. -On 09/02/21 at 8:00am, the resident's blood glucose was documented as 180, the SSI order was for 1 unit of insulin, but no insulin was documented as administered. -On 09/04/21 at 8:00pm, the resident's blood glucose was documented as 299, the SSI order was for 4 units of Humalog insulin, but 3 units were documented as administered. -On 09/05/21 at 8:00am, the resident's blood glucose was documented as 220, the SSI order was for 3 units of Humalog insulin, but 4 units were documented as administered.	D 358		

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D 358	Continued From page 71 -On 09/08/21 at 8:00pm, the resident's blood glucose was documented as 181, the SSI order was for 1 unit of Humalog insulin, but zero units were documented as administered. -On 09/17/21 at 8:00am, the resident's blood glucose was documented as 222, the SSI order was for 4 unit of Humalog insulin, but no insulin was documented as administered. -On 09/18/21 at 8:00am, the resident's blood glucose was documented as 189, the SSI order was for 1 unit of Humalog insulin, but zero units were documented as administered. -From 09/01/21 to 09/30/21, an incorrect amount of insulin was administered 6 of 60 opportunities. Review of Resident #2's October 2021 eMAR revealed: -There was an entry for 1 unit of Humalog insulin for blood glucose levels of 170-190, administer 2 units of Humalog insulin for blood glucose levels of 191-200, administer 3 units of Humalog insulin for blood glucose levels of 201-220, and administer 4 units of Humalog insulin for blood glucose levels of 221 or greater. -On 10/01/21 at 8:00pm, the resident's blood glucose was documented as 203, the SSI order was for 3 unit of Humalog insulin, but no insulin was documented as administered. -On 10/07/21 at 8:00am, the resident's blood glucose was documented as 171, the SSI order was for 1 units of Humalog insulin, but no insulin was documented as administered. -On 10/10/21 at 8:00pm, the resident's blood glucose was documented as 202, the SSI order was for 3 units of Humalog insulin, but no insulin was documented as administered. -On 10/15/21 at 8:00pm, the resident's blood glucose was not documented, but 4 units of Humalog insulin were documented as administered.	D 358		

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D 358	Continued From page 72 -On 10/20/21 at 8:00am, the resident's blood glucose was documented as 185, the SSI order was for 1 unit of Humalog insulin, but 2 units were documented as administered. -On 10/24/21 at 8:00pm, the resident's blood glucose was documented as 191, the SSI order was for 2 unit of Humalog insulin, but zero units were administered. -On 10/31/21 at 8:00pm, the resident's blood glucose was documented as 313, the SSI order was for 4 unit of Humalog insulin, but 3 units were documented as administered. -From 10/01/21 to 10/31/21, an incorrect amount of Humalog insulin was administered 7 of 62 opportunities. Review of Resident #2's November 2021 eMAR revealed: -There was an entry for 1 unit of Humalog insulin for blood glucose levels of 170-190, administer 2 units of Humalog insulin for blood glucose levels of 191-200, administer 3 units of Humalog insulin for blood glucose levels of 201-220, and administer 4 units of Humalog insulin for blood glucose levels of 221 or greater. -On 11/03/21 at 8:00am, the resident's blood glucose was documented as 170, the SSI order was for 1 unit of Humalog insulin, but no insulin was documented as administered. -On 11/03/21 at 8:00pm, the resident's blood glucose was documented as 287, the SSI order was for 4 units of Humalog insulin, but 3 units were administered. -On 11/09/21 at 8:00pm, the resident's blood glucose was documented as 186, the SSI order was for 1 units of insulin, but no insulin was documented as administered. -On 11/10/21 at 8:00am, the resident's blood glucose was documented as 211, the SSI order was for 3 unit of insulin, but no insulin was	D 358		

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documented as administered.
-From 11/01/21 to 11/12/21, an incorrect amount of insulin was administered 4 of 23 opportunities.

Interview with a medication aide (MA) on 11/12/21 at 10:20am revealed:
-The resident requested a different amount of insulin than what was ordered at times.
-She administered the requested amount of insulin in the past.
-She did not notify the Resident Care Coordinator (RCC) or the Executive Director (ED) when she administered a different amount than what was ordered by the resident's primary care provider (PCP).
-She did not notify the resident's PCP when she had administered a different amount of insulin than what he had ordered.

Telephone interview with Resident #2's family member on 11/10/21 at 3:49pm revealed:
-She was aware the resident had an SSI.
-She expected the facility to follow the SSI orders provided by the resident's PCP.
-She expected the facility to notify the PCP and request new orders if needed when the resident requested a different amount of insulin than recommended by the SSI.

Interview with Resident #2 on 11/12/21 at 10:30am revealed:
-She checked her finger stick blood sugar (FSBS) independently.
-She reported the results to the MA twice daily morning and evening.
-She requested a different amount of insulin than what was ordered at times because she did not want her "sugar to bottom out".
-The MAs administered the amount she requested most of the time.

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D 358	Continued From page 74 Telephone interview with Resident #2's PCP on11/12/21 at 12:15pm revealed: -The last order for an SSI for Humalog was written on 06/10/21. -The resident was last seen by the PCP in July 2021. -The PCP's office had not been notified the resident was administered an amount of Humalog insulin other than what was ordered on 06/10/21. -The facility had not requested an order to change the amount of insulin ordered per the resident's request. Interview with Executive Director (ED) on 11/12/21 at 4:04pm revealed: -Resident #2 requested a different amount of insulin than what was ordered at times. -She was aware the MAs administered the requested amount of insulin. -She had not contacted the resident's PCP for an order to change the amount of insulin ordered per the resident request. Review of the facility's medication policy revealed it was the policy of the facility to administer all medications as ordered by the residents' physician 4. Review of Resident #3's FL-2 dated 01/18/21 revealed: -Diagnoses included mental confusion, hyperglycemia, hyperlipidemia, migraine headaches, and hypothyroidism. -She was intermittently disoriented. -She was ambulatory, and an assistive device was not indicated. Review of Resident #3's primary care provider (PCP) order dated 08/24/21 revealed there was a	D 358		

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medication order for Sinemet Extended Release 25-100mg take 1 tablet three times a day (Sinemet ER is used to treat symptoms of Parkinson's disease or Parkinson-like symptoms).

Review of Resident #3's After Visit Summary dated 10/25/21 revealed:
-There was a medication change for Sinemet CR.
-Sinemet CR was to be administered 4 times daily for 360 days at 8:00am, 12:00pm, 4:00pm, and 9:00pm.

Review of Resident #3's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Sinemet Extended Release (ER) 25-100mg 1 tablet 3 times a day.
-Sinemet ER 25-100mg was scheduled for administration at 8:00am, 2:00pm, and 8:00pm.
-Sinemet ER was documented as administered for 86 out of 90 doses from 09/01/21 - 09/30/21.

Review of Resident #3's October 2021 eMAR revealed:
-There was an entry for Sinemet ER 25-100mg 1 tablet 3 times a day.
-Sinemet ER 25-100mg was scheduled for administration at 8:00am, 2:00pm, and 8:00pm.
-Sinemet ER was documented as administered for 91 out of 93 doses from 10/01/21 - 10/31/21.
-There was no entry for Sinemet QID from 10/25/21 to 10/31/21.

Review of Resident #3's November 2021 eMAR dated 11/01/21 - 11/11/21 revealed:
-There was an entry for Sinemet Extended Release (ER) 25-100mg 1 tablet 3 times a day.
-Sinemet ER 25-100mg was scheduled for administration at 8:00am, 2:00pm, and 8:00pm.

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-Sinemet ER was documented as administered three times a day for 21 out of 21 doses from 11/01/21 - 11/07/21.
-There was an additional entry for Sinemet ER 25-100mg 1 tablet 4 times a day.
-Sinemet ER 25-100mg was scheduled for administration at 8:00am, 12:00pm, 5:00pm, and 10:00pm.
-On 11/08/21 at 8:00am, Sinemet ER was documented as administered 4 times a day.
-Sinemet ER was documented as administered 4 times a day from 11/08/21 - 11/09/21.

Interview with a pharmacy technician at the facility's contracted pharmacy on 11/12/21 at 9:19am revealed:
-The current order for Resident #3's Sinemet ER 25-100mg in the pharmacy's computer system was Sinemet ER 25-100mg 1 tablet 3 times a day.
-There was not an order for Resident #3's Sinemet ER 25-100mg to be administered 4 times a day.

Interview with Resident #3's on 11/12/21 at 1:37pm revealed the facility staff administered her Sinemet to her 4 times a day; she was not sure when she started receiving the Sinemet 4 times a day.

Interview with the Executive Director (ED) on 11/12/21 at 1:02pm revealed:
-New FL-2s and hospital discharge summaries should be faxed to the pharmacy by the Medication Aides, Resident Care Coordinator, or Health and Wellness Director (HWD).
-The pharmacy staff was responsible for entering orders into the electronic medication administration record (eMAR) system.
-The medication orders had to be verified in the

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eMAR system by facility staff prior to the order becoming active on the eMAR.
-The ED, RCC, HWD, or the MAs had access to verify medication orders.
-The HWD position had been vacant since July 2021 and a new HWD had been hired and started this week but she was in orientation.
-She expected medications to be available and administered as ordered.

Telephone interview with the Resident #3's primary care provider (PCP) on 11/12/21 at 5:12pm revealed:
-When a new medication was ordered she expected the facility to process the new medication order as soon as possible or the same day.
-She was not aware there was approximately a 14-day delay in implementing the increase in frequency from 3 times a day to 4 times a day for Resident #3's Sinemet ER.
-She expected residents' medications to be administered as ordered.

A request was made for Resident #3's pharmacy dispensing history from 09/01/21 to 11/12/21 on 11/12/21 at 9:20am but was not received prior to survey exit on 11/12/21.

5. Review of Resident #5's current FL-2 dated 08/11/21 revealed diagnoses included encephalopathy unspecified, type II diabetes mellitus, and adult failure to thrive.

Review of a handwritten facility requests for information provided to the facility dated 11/09/21 at 1:58pm and 11/10/21 at 2:49pm revealed:
-Requests were made for Resident #5's orders from 5/2021 to 11/2021.
-The requested documentation was not received

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D 358	Continued From page 78 prior to survey exit on 11/12/21. Interview with a pharmacy technician at the facility's contracted pharmacy on 11/12/21 at 10:28am revealed: -There was a medication order dated 09/23/21 for Trazodone 50 mg 1 tablet at bedtime (Trazodone is used as an antidepressant and sedative). -Resident #5's Trazodone HCL 50mg was last dispensed to the facility on 09/23/21 for a 30-day supply. -There had no additional Trazodone dispensed to the facility since 09/23/21. -She did not see any requests for refills within the pharmacy's computer system. Review of Resident #5's consultant pharmacist progress note dated 10/08/21 revealed there was a PCP order dated 09/24/21 for Trazodone 50 mg at bedtime. Review of Resident #5's record revealed there was no documentation of an order for Trazodone 50 mg 1 tablet at bedtime. Observations on 11/12/21 at 9:58am of medications on hand for Resident #5 revealed there was no Trazodone HCL 50mg tablets available for administration. Review of Resident #5's September 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Trazodone HCL 50mg 1 tablet at bedtime. -Trazodone HCL 50mg was scheduled for administration at 8:00pm. -Trazodone HCL 50mg was documented as administered for 7 out of 7 doses from 09/24/21 - 09/30/21.	D 358		

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D 358	Continued From page 79 Review of Resident #5's October 2021 eMAR revealed: -There was an entry for Trazodone HCL 50mg 1 tablet at bedtime. -Trazodone HCL 50mg was scheduled for administration at 8:00pm. -Trazodone HCL 50mg was documented as administered for 31 out of 31 doses from 10/01/21 - 10/31/21. Review of Resident #5's November 2021 eMAR dated 11/01/21 - 11/09/21 revealed: -There was an entry for Trazodone HCL 50mg 1 tablet at bedtime. -Trazodone HCL 50mg was scheduled for administration at 8:00pm. -Trazodone HCL 50mg was documented as administered for 7 out of 9 doses from 11/01/21 - 11/09/21. -There was a note documented on 11/09/21 at 7:49pm by the medication aide Trazodone HCL 50mg was not on the medication cart. Interview with the Executive Director (ED) on 11/12/21 at 1:02pm revealed: -The facility did not receive automatic cycle fills from the pharmacy. -The medication aides (MAs) were responsible for reordering medications when there was a 7-day supply of medication remaining. -The MAs should let the ED know if a medication was unavailable and the pharmacy did not send it. -The MA/Supervisor was responsible for doing medication cart audits as needed when instructed by the ED. -She expected medications to be available and administered as ordered.	D 358		

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D 358	Continued From page 80 Telephone interview with the Resident #5's primary care provider (PCP) on 11/12/21 at 5:12pm revealed: -She expected residents' medications to be administered as ordered. -She was not aware Resident #5 had no Trazodone 50mg tablets available on the medication cart to be administered for approximately 20-days. -She expected medication refills to be requested before the medication became unavailable for administration. -She expected the staff to only document on the MARs when a medication was administered to the resident. -It was important for the MARs to have an "accurate" account of what was administered to residents. Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable. Attempted telephone interview with Resident #5's hospice provider on 11/12/21 at 12:30pm was unsuccessful. A request was made on 11/12/21 at 10:30am for Resident #5 pharmacy dispensing history from 9/2021 to 11/12/21 and Resident #5's PCP order dated 09/23/21 for Trazodone 50mg 1 tablet at bedtime but was not received prior to survey exit on 11/12/21. _____ The facility failed to administer medications as ordered for 2 of 3 residents (#2, #8) observed during the medication pass including Resident #8 whose orders for two medications used to reduce the risk of heart attack were not implemented after a hospitalization with elevated troponin	D 358		

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D 358	Continued From page 81 levels, indicating the resident had a heart attack; and Resident #2 continued to receive 30 units of long-acting insulin after the order was changed during a hospitalization on 09/16/21. Resident #1 did not receive a medication used to treat heart failure as ordered on 09/07/21 resulting in a second hospitalization for exacerbation of congestive heart failure from 09/23/21 - 09/27/21 and Resident #1 received 8 doses of expired insulin putting the resident at risk of having high blood sugar. There was a 14-day delay in increasing Resident #3's medication used to treat Parkinson's Disease and Resident #5 did not receive their ordered medication for depression for 20 days. The facility's failure resulted in serious physical harm and serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-21 on 11/10/21 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 12, 2021.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment;	D 367		

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D 367	Continued From page 82 (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: Based on observations, interviews, and record reviews, the facility failed to ensure the accuracy of medication administration records for 3 of 5 sampled residents (#1, #2, #5) related to documented administration of a topical antifungal / corticosteroid cream that was not administered to the resident (#2); a medication for congestive heart failure that was unavailable (#1); and a medication for depression/sleep that was unavailable (#5). The findings are: 1. Review of Resident #2's current FL-2 dated 09/15/21 revealed: -Diagnoses included acute on chronic respiratory failure, acute kidney injury, and diabetes mellitus. -Current medications were referenced to a recent hospital discharge summary. Review of Resident #2's hospital discharge medications dated 09/16/21 revealed an order for nystatin-traimcinolone cream one application twice daily was signed by the discharging provider. (Nystatin is used to treat fungal skin infections. Triamcinolone is an anti-inflammatory	D 367		

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D 367	Continued From page 83 corticosteroid that reduces swelling, itching, and redness.) Review of Resident #2's September 2021 electronic medication administration record (eMAR) revealed: -There was an entry for nystatin-triamcinolone cream to be spread topically to affected area twice a day. -No refills were available for the cream. -The start date for the cream was 09/18/21. -The application of cream was documented from 09/18/21 to 09/30/21 at 8:00am and 8:00pm. Review of Resident #2's October 2021 eMAR revealed: -There was an entry for nystatin-traimcinolone cream to be spread topically to affected area twice a day. -No refills were available for the cream. -The start date for the cream was 09/18/21. -The application of cream was documented from 10/01/21 to 10/31/21 at 8:00am and 8:00pm. Review of Resident #2's November 2021 eMAR on revealed: -There was an entry for nystatin-traimcinolone cream to be spread topically to affected area twice a day. -No refills were available for the cream. -The start date for the cream was 09/18/21. -The application of cream was documented from 11/01/21 to 11/11/21 at 8:00am and 8:00pm. Interview with Resident #2 on 11/12/21 at 5:00pm revealed: -She was "prescribed the nystatin cream when she discharged from the hospital in September because she was on so many antibiotics and developed vaginosis".	D 367		

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-She applied the cream twice daily until the end of September 2021.
-The facility staff did not apply the cream.
-She did not apply the cream in October 2021 or November 2021.
-The cream was stored in her personal bathroom since 09/18/21.
-She had 2 tubes of the cream; one from the hospital and one sent from the facility pharmacy.
-One tube of cream remained on hand in the resident's room.
-She had notified the medication aides (MA) she was no longer using the cream on multiple occasions between 10/01/21 and 11/12/21.

Interview with the Executive Director (ED) on 11/12/21 at 4:04pm revealed:
-She was not aware the resident was had not used the nystatin-triamcinolone cream in October 2021 and November 2021.
-She was not aware the resident had informed the staff she no longer used the cream.
-MAs were expected to accurately document medication administration on the resident's eMAR.
-MAs were expected to notify the Resident Care Coordinator (RCC) or the ED when residents no longer used a medication.
-The RCC or the ED were expected to notify the resident's primary care provider (PCP) if the resident no longer used a medication and obtain new orders.

Interview with Resident #2's PCP on 11/12/21 at 12:15 revealed nystatin-triamcinolone was not documented in the resident's office records.

2. Review of Resident #1's FL-2 dated 09/27/21 revealed diagnoses included acute on chronic systolic congestive heart failure, acute renal

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failure, atrial fibrillation, and coronary artery disease.

Review of Resident #1's hospital discharge summary and discharge instructions dated 09/07/21 revealed:
-The resident's date of admission to the hospital was 08/31/21 and the discharge date was 09/07/21.
-The resident presented to the emergency room (ER) with shortness of breath and leg swelling.
-The resident's discharge diagnoses included acute on chronic systolic congestive heart failure, atrial fibrillation, congestive heart failure exacerbation, shortness of breath, leg swelling, anemia, cellulitis, stage 3 chronic kidney disease, ischemic cardiomyopathy, and hypomagnesemia.
-There was an order for Entresto 49-51mg take 1 tablet two times a day. (Entresto is used for the treatment of symptomatic chronic heart failure. According to the manufacturer, Entresto is used to help reduce the risk of death and hospitalization for heart failure.)

Review of Resident #1's prescription dated 09/07/21 revealed an order for Entresto 49-51mg 1 tablet two times a day for 60 tablets and no refills by the hospital provider.

Review of Resident #1's hospital discharge summary dated 09/27/21 revealed:
-The resident's date of admission to the hospital was 09/23/21 and the discharge date was 09/27/21.
-The resident was diagnosed with acute on chronic congestive heart failure.
-There was an order for Entresto 49-51mg take 1 tablet two times a day.

Review of Resident #1's September 2021

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electronic medication administration record (eMAR) revealed:
-There was an entry for Entresto 49-51mg 1 tablet twice a day scheduled for 8:00am and 8:00pm.
-Documentation for the administration of Entresto started at 8:00am on 09/08/21.
-Entresto was documented as not administered on 16 of 46 occasions from 09/08/21 - 09/30/21 due to the medication being unavailable and on reorder.
-The 16 occasions Entresto was documented as unavailable included: 8:00am on 09/15/21, 09/18/21, 09/21/21, and 09/30/21; and 8:00pm from 09/13/21 - 09/15/21, 09/17/21 - 09/19/21, 09/21/21 - 09/22/21, and 09/27/21 - 09/30/21.
-Entresto was not documented as administered on 8 occasions from 8:00pm on 09/23/21 - 8:00am on 09/27/21 due to the resident being out of the facility and in the hospital.
-There were 22 doses of Entresto documented as administered from 09/08/21 - 09/30/21.

Review of Resident #1's October 2021 eMAR revealed:
-There was an entry for Entresto 49-51mg 1 tablet twice a day scheduled for 8:00am and 8:00pm.
-Entresto was documented as not administered on 25 of 62 occasions from 10/01/21 - 10/31/21 due to the medication being unavailable
-The 25 occasions Entresto was documented as unavailable included: 8:00am on 10/02/21 - 10/03/21 and 10/12/21; and 8:00pm from 10/01/21 - 10/03/21, 10/05/21 - 10/16/21, 10/19/21 - 10/22/21, and 10/24/21 - 10/26/21.
-There were 37 doses of Entresto documented as administered from 10/01/21 - 10/31/21.

Review of Resident #1's November 2021 eMAR

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D 367	Continued From page 87 revealed: -There was an entry for Entresto 49-51mg 1 tablet twice a day scheduled for 8:00am and 8:00pm. -Entresto was documented as not administered at 8:00pm from 11/07/21 - 11/09/21 due to the medication being unavailable. -There was documentation of a "courtesy fill" on 11/09/21 and Entresto was documented as administered starting at 8:00am on 11/10/21. -There were 13 doses of Entresto documented as administered from 11/01/21 - 11/08/21. Observation of Resident #1's medications on hand on 11/12/21 at 11:54am revealed: -There was a supply of 60 Entresto 49-51mg tablets dispensed on 11/09/21. -There were 55 of 60 Entresto tablets remaining. Interview with a medication aide (MA) on 11/12/21 at 11:54am revealed: -The facility received a courtesy fill of Entresto for the first time on 11/09/21. -She had no explanation for why Entresto was documented as administered on the eMAR on multiple occasions when none was available to administer. Interview with the Executive Director (ED) on 11/12/21 at 1:02pm revealed: -She expected medications to be available and administered as ordered. -She expected the MAs to document on the eMAR accurately. -The MAs should not have documented the Entresto was administered when it was not available and not administered. Based on observations, interviews, and record review for Resident #1's Entresto:	D 367		

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-There were 60 Entresto tablets dispensed from 09/07/21 - 11/08/21.
-The MAs documented 72 tablets were administered but only 60 tablets were available to administer from 09/07/21 - 11/08/21.
-The eMARs did not accurately reflect the administration of Entresto.

3. Review of Resident #5's current FL-2 dated 08/11/21 revealed diagnoses included encephalopathy unspecified, type II diabetes mellitus, and adult failure to thrive.

Interview with a pharmacy technician at the facility's contracted pharmacy on 11/12/21 at 10:28am revealed:
-There was a medication order dated 09/23/21 for Trazodone 50 mg 1 tablet at bedtime (Trazodone is used as an antidepressant and sedative).
-Resident #5's Trazodone HCL 50mg was last dispensed to the facility on 09/23/21 for a 30-day supply.
-There had no additional Trazodone dispensed to the facility since 09/23/21.
-She did not see any requests for refills within the pharmacy's computer system.

Observations on 11/12/21 at 9:58am of medications on hand for Resident #5 revealed there was no Trazodone HCL 50mg tablets available for administration.

Interview with a medication aide (MA) on 11/12/21 at 10:00am revealed:
-She was not sure when a medication cart audit was last completed in the Special Care Unit.
-MAs were expected to document the administration of a resident's medication(s) on the electronic medication administration record (eMAR) only after they observe the resident take

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D 367	Continued From page 89	D 367		

the medication(s).
-She was not aware Resident #5 had no Trazodone 50mg tablets available on the medication cart to be administered.

Review of Resident #5's record revealed there was no documentation of an order for Trazodone 50 mg 1 tablet at bedtime.

Review of Resident #5's September 2021 eMAR revealed:
-There was an entry for Trazodone HCL 50mg 1 tablet at bedtime.
-Trazodone HCL 50mg was scheduled for administration at 8:00pm.
-Trazodone HCL 50mg was documented as administered for 7 out of 7 doses from 09/24/21 - 09/30/21.

Review of Resident #5's October 2021 eMAR revealed:
-There was an entry for Trazodone HCL 50mg 1 tablet at bedtime.
-Trazodone HCL 50mg was scheduled for administration at 8:00pm.
-Trazodone HCL 50mg was documented as administered for 31 out of 31 doses from 10/01/21 - 10/31/21.

Review of Resident #5's November 2021 eMAR dated 11/01/21 - 11/09/21 revealed:
-There was an entry for Trazodone HCL 50mg 1 tablet at bedtime.
-Trazodone HCL 50mg was scheduled for administration at 8:00pm.
-Trazodone HCL 50mg was documented as administered for 7 out of 9 doses from 11/01/21 - 11/09/21.
-There was a note documented on 11/09/21 at 7:49pm by the medication aide Trazodone HCL

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D 367	Continued From page 90 50mg was not on the medication cart. Interview with the Executive Director (ED) on 11/12/21 at 1:02pm revealed she expected documentation on the eMAR to be accurate. Telephone interview with the Resident #5's PCP on 11/12/21 at 5:12pm revealed it was important for the MARs to have an "accurate" account of what was administered to residents.	D 367		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to physical environment, health care, medication administration, and adult care home medication aides; training and competency evaluation requirements. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure 9 of 9 exit doors accessible for residents' use were equipped with a sounding device that activated for the safety of 1 of 1 sampled resident who was	D912		

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D912	Continued From page 91 disoriented and who eloped from the facility without staff knowledge (Resident #3). [Refer to Tag 067, 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation).] 2. Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 2 of 5 sampled residents (#1, #2) related to not scheduling a follow-up appointment with the cardiology provider, not obtaining labwork as ordered, and not notifying the provider of weight gain for a resident with two hospitalizations for fluid overload and an exacerbation of congestive heart failure (#1); and not notifying the provider of blood sugars greater than 300 as ordered for a resident with diabetes who was receiving insulin (#2). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Unabated Type A2 Violation).] 3. Based on observations, record reviews, and interviews, the facility failed to ensure the implementation of physician's orders for 1 of 5 sampled residents (#1) regarding orders for a fluid restriction and daily weights with parameters after the resident was hospitalized with fluid overload and exacerbation of congestive heart failure. [Refer to Tag 276, 10A NCAC 13F .0902(c) Health Care (Type A2 Violation).] 4. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 3 residents (#2, #8) observed during the medication passes evidenced by errors which included a medication to treat high blood pressure, heart failure, and to reduce the risk of death after a heart attack, a medication to reduce the risk of a heart attack, a Vitamin D supplement, and a calcium supplement (#8); a long-acting insulin to control high blood	D912		

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D912	Continued From page 92 sugar, a medication to treat chest pain and heart disease, and a medication to treat skin rash (#2); and for 4 of 5 residents (#1, #2, #3, #5) sampled for record review including errors with a medication to treat congestive heart failure, a diuretic for fluid retention, and an expired insulin (#1); a sliding scale rapid-acting insulin to control high blood sugar (#2); a medication to treat a central nervous system disorder (#3), and a medication to treat depression (#5). [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation).] 5. Based on interviews and record reviews, the facility failed to ensure 3 of 6 sampled staff (C, D, and E) who administered medications had completed the 5, 10, or 15-hour medication administration training course or had documentation of the medication aide verification form. [Refer to Tag 935, G.S.131D-4.5B(b) Adult care home medication aides training and competency evaluation requirements (Type B Violation).]	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the	D935		

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D935	Continued From page 93 Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 3 of 6 sampled staff (C, D, and E) who administered medications had completed the 5, 10, or 15-hour medication administration training course or had documentation of the medication aide verification form.	D935		

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D935	Continued From page 94 The findings are: 1. Review of Staff C's personnel record on 11/12/21 revealed: -Staff C was hired on 05/19/17. -There was documentation Staff C passed the written medication aide (MA) exam on 10/16/17. -There was documentation of a Medication Clinical Skills Competency Evaluation form dated 11/08/17. -There was no documentation Staff C completed the 5, 10, or 15-hour (hr.) medication administration training course. -There was no documentation of the facility MA Verification form prior to employment as a MA. Review of a resident's September 2021-November electronic medication administration records (eMARs) revealed: -Staff C administered medications on 4 days from 09/01/21-09/30/21 including 09/10/21, 09/12/21, 09/21/21, and 09/29/21. -Staff C administered medications on 1 day from 10/01/21-10/31/21 on 10/30/21. -Staff C administered medications on 3 days from 11/01/21-11/09/21 including 11/01/21, 11/08/21, and 11/09/21. Review of an additional resident's September 2021-November 2021 eMARs revealed: -Staff C administered a topical medication on 2 days from 09/01/21 -09/30/21 including 09/21/21 and 09/28/21. -Staff C administered a topical medication on 1 day from 10/01/21-10/31/21 including 10/30/21. -Staff C administered a topical medication on 3 days from 11/01/21-11/12/21 including 11/01/21, and 11/08/21-11/09/21. Interview with Staff C on 11/12/21 at 5:00pm	D935		

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D935	Continued From page 95 revealed: -She had completed the required 5, 10, and 15-hour medication administration training course around 2018. -She was not sure if a copy of the 5,10, and 15-hour training certificates were in the facility's employee files. -She was certain she had a copy at home and would fax the requested copy. Interview with the Executive Director (ED) on 11/12/21 at 11:08am revealed: -She could not locate Staff's C 15-hour medication administration training course certificate of completion. -She was not sure where the former Business Office Management put the document. Refer to the interview with ED on 11/12/21 at 11:08am. 2. Review of Staff D's personnel record on 11/12/21 revealed: -Staff D was hired on 09/06/17. -There was documentation Staff C passed the written medication aide (MA) exam on 02/29/16. -There was documentation of a Medication Clinical Skills Competency Evaluation form dated 09/25/21. -There was no documentation Staff C completed the 5, 10, or 15-hour (hr.) medication administration (MA) training course. -There was no documentation of the facility MA Verification form prior to employment as a MA. Review of a resident's September 2021 - November 2021 electronic medication administration records (eMAR) revealed: -Staff D administered a medication on 1 of 30 days from 09/01/21 - 09/30/21 on 09/29/21.	D935		

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D935	Continued From page 96 -Staff D administered medications on 9 of 31 days from 10/01/21 - 10/31/21 including 10/13/21, 10/18/21, 10/19/21, 10/20/21, 10/21/21, 10/26/21, 10/27/21, 10/28/21, and 10/29/21. -Staff D administered medications on 6 of 30 days from 11/01/21 - 11/09/21 including 11/01/21, 11/02/21, 11/03/21, 11/04/21, 11/05/21, and 11/09/21. -Staff D made an error by documenting administration of Trazodone for a resident on 10/26/21, 10/27/21, 10/28/21, and 10/29/21 after the medication had become unavailable on 10/24/21 and was no longer available on the medication cart to administer (Trazodone is antidepressant and sedative). -Staff D made an error by documenting administration of Trazodone for a resident on 11/01/21, 11/02/21, 11/03/21, 11/04/21, and 11/05/21 after the medication had become unavailable on 10/24/21 and was no longer available on the medication cart to administer. Review of an additional resident's September 2021-November 2021 eMARs revealed: -Staff D administered a topical medication 1 day from 09/01/21-09/30/21 including 09/30/21. -Staff D administered a topical medication 5 days from 10/01/21-10/31/21 including 10/07/21, 10/14/21, 10/16/21, 10/24/21, and 10/31/21. -Staff D administered a topical medication 5 days from 11/01/-11/12/21 including 11/02/21, 11/04/21-11/07/21. Interview with the Executive Director (ED) on 11/12/21 at 11:08am revealed: -She was in the process of compiling Staff's D medication aide qualifications. -She was not sure where the former Business Office Management put the documents.	D935		

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D935	Continued From page 97 Refer to the interview with ED on 11/12/21 at 11:08am. 3. Review of Staff E's personnel record on 11/12/21 revealed: -Staff E was originally hired on 06/20/13 and then re-hired on 11/02/20. -There was documentation Staff C passed the written medication aide (MA) exam on 06/27/13. -There was documentation of a Medication Clinical Skills Competency Evaluation form dated 09/25/21. -There was no documentation Staff C completed the 5, 10, or 15-hour (hr.) medication administration training course. -There was no documentation of the facility MA Verification form prior to employment as a MA. Review of a resident's October 2021- November 2021 electronic medication administration records (eMAR) revealed: -On 10/01/21 at 8:00pm, the resident's fingerstick blood sugar (FSBS) result was 203; the sliding scale insulin entry indicated the resident should receive 3 units of insulin; Staff E documented the administration of 0 units. -On 10/07/21 at 8:00am, the resident's FSBS result was 171; the sliding scale insulin entry indicated the resident should receive 1 unit of insulin; Staff E documented the administration of 0 units. -On 10/15/21 at 8:00pm, the resident's FSBS result was 287; the sliding scale insulin entry indicated the resident should receive 4 units of insulin; Staff E documented the administration of 3 units. -On 11/03/21 at 8:00pm, the resident's FSBS result was 287; the sliding scale insulin entry indicated the resident should receive 4 units of insulin; Staff E documented the administration of	D935		

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D935	Continued From page 98 3 units. -On 11/10/21 at 8:00pm, the resident's FSBS result was 211; the sliding scale insulin entry indicated the resident should receive 3 units of insulin; Staff E documented the administration of 0 units. Review of an additional resident's September 2021-November 2021 eMARs revealed: -Staff E administered a topical medication 3 days from 09/01/21-09/30/21 including 09/20/21, 09/22/21, and 09/28/21. -Staff E administered a topical medication 12 days from 10/01/21-10/31/21 including 10/01/21-10/03/21, 10/05/21, 10/07/21, 10/12/21, 10/15/21, 10/19/21-10/20/21, 10/26/21, and 10/28/21-10/29/21. -Staff E administered a topical medication 7 days from 11/01/21-11/12/21 including 11/01/21-11/03/21, 11/05/21-11/06/21, and 11/10/21-11/11/21. Interview with the Executive Director (ED) on 11/12/21 at 11:08am revealed: -She could not locate Staff's E 15-hour medication administration training course certificate of completion. -She was not sure where the former Business Office Management put the document. Refer to the interview with ED on 11/12/21 at 11:08am. Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation). _____ Interview with the ED on 11/12/21 at 11:08am revealed: -The facility did not currently have a Business Office Manager (BOM); a date the position	D935		

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D935	Continued From page 99 became vacant was not provided. -Prior to the BOM's departure, she was responsible to ensure the 5, 10, or 15 hr. medication administration training course was in the staff folder. -Without a BOM, it was ultimately the ED's responsibility to ensure accurate staff folders. -She had no process to ensure the accuracy of the staff folders. _____ The facility failed to ensure 3 of 6 sampled medication aides, who were administering medications including insulin, to residents in the facility, completed the 5, 10, or 15-hour medication administration training course or had documentation of the medication aide verification form. The facility's failure to ensure MAs met training requirements prior to the administration of medications resulted in insulin not administered as ordered per the sliding scale parameters and inaccurate medication administration records and increased the risk for medication errors which was detrimental to the health, safety, and welfare of the residents and constitutes an Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/15/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 27, 2021.	D935		