Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL055008 | A. BUILDING: _____ B. WING _____ | 08/16/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| WEXFORD HOUSE | 3900 WEXFORD LANE DENVER, NC 28037 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual survey on August 15-16, 2023. | D 000 | **"Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law."** | |
| D 276 | 10A NCAC 13F .0902(c)(3-4) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(c) The facility shall assure documentation of the following in the resident's record:<br>(3) written procedures, treatments or orders from a physician or other licensed health professional; and<br>(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to implement physician's orders for 1 of 5 sampled residents for blood pressure checks three times weekly (Resident #3).<br><br>The findings are:<br><br>Review of Resident #3's current FL2 dated 04/04/23 revealed diagnoses included hip fracture and weakness.<br><br>Review of Resident #3's Primary Care Provider's (PCP) progress note dated 06/13/23 revealed:<br>-Resident #3 had a diagnosis of hypertension (high blood pressure).<br>-Resident #3 was prescribed two medications to control her blood pressure.<br>-There was a new order to check Resident #3's blood pressure three times weekly.<br><br>Review of Resident #3's June 2023 electronic Medication Administration Record (eMAR) revealed: | D 276 | 10A NCAC 13F .0902(c)(3-4) Health Care<br>The Executive Director will review the rule area listed above and the following Facility Policy with the Resident Care Coordinator: Medication Services/Pharmaceutical Care Services with the Resident Care Coordinator to ensure proper requirements are understood and processes are in place to prevent further non compliance.<br><br>The Executive Director, Resident Care Coordinator will retrain all necessary core staff members (Med Aides/ SICS) on the Rule Area stated above and policies and procedures aligned with Medication compliance in place for ensuring all written procedures, treatments or orders from a physician or other licensed health professional is documented in the resident's record and implemented through our EMAR system. These Policies include: New Order Process, Cart Audit/Medications on Hand Review, Medication Errors, New Order for Therapy and/or Equipment.<br><br>Resident Care Coordinator/Med Aides/SICs will receive in-servicing on the importance of Cart Audits related to Medication Management.<br><br>The Resident Care Coordinator will complete a 100% cart audit to ensure MAR is completely reconciled with medications on hand. Any medications not available will be ordered immediately. Med Techs will complete weekly assigned cart audits for meds on hand. Completed cart audits will be submitted to the Resident Care Coordinator/ED upon completion for verification and follow up.<br><br>Resident Care Coordinator will review MARs weekly for new orders that have been provided by a Resident's Physician/Licensed Healthcare Professional and ensure facility has implemented accurately according to orders. Care Coordinator will report any medication errors as needed to PCP/LHP and immediately take necessary steps to correct the written order within the EMAR system and Residents Record and receive any clarification necessary by PCP/LHP. | 10/31/2023 |



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Felicia Miles, Executive Director | 9/13/2023



Reviewed and Acknowledged 09/20/23
Susan S Melton, RN
Susan S Melton RN

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-There was an entry for monthly vital signs, including blood pressure, to be completed on the 8th of each month.
-There was documentation the resident's blood pressure was checked on 06/08/23.
-There were no other entries for blood pressure checks.

Review of Resident #3's July 2023 eMAR revealed:
-There was an entry for monthly vital signs, including blood pressure, to be completed on the 8th of each month.
-There was documentation the resident's blood pressure was checked on 07/08/23.
-There was an entry to check Resident #3's vital signs each shift for 72 hours following a fall beginning 07/17/23.
-The entry was documented each shift from 07/17/23 to 07/20/23.
-There were no other entries for blood pressure checks.

Review of Resident #3's August 2023 eMAR revealed:
-There was an entry for monthly vital signs, including blood pressure, to be completed on the 8th of each month.
-The entry was documented not completed on 08/08/23 due to resident's refusal.
-There were no other entries for blood pressure checks.

Telephone interview with a Pharmacist with the facility's contracted pharmacy on 08/16/23 at 2:10pm revealed PCP orders for blood pressure readings three times per week were to be placed on the resident's eMAR by the facility.

Interview with a medication aide (MA) on

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| D 276 | Continued From page 2<br><br>08/16/23 at 12:15pm revealed:<br>-She was not aware Resident #3 had an order for blood pressure checks three times weekly.<br>-The Resident Care Coordinator (RCC) was responsible for ensuring new orders were placed on the residents' eMARs.<br>-If the RCC was not on duty, the MAs could enter new orders for blood pressures into the eMAR system.<br>-She would only be aware to take Resident #3's blood pressure three times weekly if it appeared on the eMAR or if the PCP verbally told her of the order.<br><br>Telephone interview with Resident #3's PCP on 08/16/23 at 9:18am revealed she ordered blood pressure checks three times weekly because the resident had a diagnosis of hypertension and was prescribed medications to treat it.<br><br>Interview with the Administrator on 08/16/23 at 5:20pm revealed:<br>-It was the responsibility of the RCC or Administrator to ensure orders for blood pressure checks were entered into the eMAR system.<br>-She was not aware the order for blood pressure checks for Resident #3's was not on her eMAR.<br><br>Attempted telephone interview with Resident #3's PCP on 08/16/23 at 3:45pm was unsuccessful.<br><br>Based on observations, record review and interviews it was determined Resident #3 was not interviewable. | D 276 | | |
| D 344 | 10A NCAC 13F .1002(a) Medication Orders<br><br>10A NCAC 13F .1002 Medication Orders<br>(a) An adult care home shall ensure contact with | D 344 | | |

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| D 344 | Continued From page 3<br>the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments:<br>(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;<br>(2) if orders are not clear or complete; or<br>(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.<br>The facility shall ensure that this verification or clarification is documented in the resident's record.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 2 of 5 sampled residents (#3 and #4) regarding orders for an antibiotic, two medications to treat high blood pressure, a fiber supplement, a stool softener (#3) and a medication to treat nerve pain (Resident #4).<br><br>The findings are:<br><br>1. Review of Resident #3's current FL2 dated 04/04/23 revealed:<br>-She was admitted to the facility from a skilled nursing facility.<br>-Diagnoses included hip fracture and weakness.<br><br>Review of Resident #3's Resident Register revealed she was admitted to the facility on 09/13/22.<br><br>Review of Resident #3's hospital discharge summary dated 03/19/23 revealed:<br>-The resident was admitted to the hospital on 03/14/23 after a fall at the facility.<br>-Resident #3 was diagnosed with a right hip | D 344 | **"Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law."**<br><br>10A NCAC 13F .1002 Medication Orders:<br>The Executive Director will review the rule area listed above and the following Facility Policy with the Resident Care Coordinator: Medication Orders- Admission to ensure proper requirements are understood and processes are in place to prevent further non compliance.<br><br>The Executive Director, Resident Care Coordinator will retrain all necessary core staff members (Med Aides/ SICS) on the Rule Area stated above and policies and procedures aligned with Medication Order compliance ensuring all necessary order verification is obtained and documentation is placed within the Residents Medical Record.<br><br>Resident Care Coordinator/Med Aides/SICs will receive in-servicing on the importance of obtaining order clarification from Resident's PCP/LHP when written orders and procedures are not clear or complete.<br><br>Resident Care Coordinator will review new orders that have been provided by a Resident's Physician/Licensed Healthcare Professional and ensure facility has a completed order. If any clarification is needed Care Coordinator will immediately take necessary steps to request clarification by PCP/LHP and submit new orders to the pharmacy to be implemented within the EMAR system and Residents Record. | 10/31/2023 |

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fracture and underwent surgery to repair the fracture.
-Resident #3 was discharged to a skilled nursing facility on 03/19/23.

a. Review of Resident #3's signed physician's orders dated 02/20/23 revealed an order for nitrofurantoin 100mg (a medication to treat or prevent infections), one capsule on Mondays, Wednesdays, and Fridays.

Review of Resident #3's current FL2 dated 04/04/23 revealed there was no order for nitrofurantoin.

Review of Resident #3's June 2023 electronic Medication Administration Record (eMAR) revealed there was an entry for nitrofurantoin 100mg one capsule on Mondays, Wednesdays, and Fridays, and there was documentation it was administered at 8:00am on Mondays, Wednesdays, and Fridays from 06/01/23 to 06/30/23.

Review of Resident #3's July 2023 eMAR revealed there was an entry for nitrofurantoin 100mg one capsule on Mondays, Wednesdays, and Fridays, and there was documentation it was administered at 8:00am on Mondays, Wednesdays, and Fridays from 07/01/23 to 07/30/23 and documented as not administered on 07/31/23.

Review of Resident #3's August 2023 eMAR revealed here was an entry for nitrofurantoin 100mg one capsule on Mondays, Wednesdays, and Fridays, and there was documentation it was administered at 8:00am on Mondays, Wednesdays, and Fridays from 08/01/23 to 08/15/23.

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| D 344 | Continued From page 5<br><br>Observation on 08/16/23 at 8:30am during the medication pass revealed the medication aide (MA) administered nitrofurantoin 100mg, one capsule to Resident #3.<br><br>Observation on 08/16/23 at 11:36am of medications on hand for Resident #3 revealed:<br>-A 7-day supply of Resident #3's medications were dispensed to the facility on 08/11/23.<br>-Resident #3's medications were dispensed in a multi-dose package that bundled medications together by date and time.<br>-Nitrofurantoin 100mg, one capsule was included in Resident #3's morning medications for Friday 08/18/23 and Monday 08/21/23.<br><br>Telephone interview with a Pharmacist with the facility's contracted pharmacy on 08/16/23 at 2:10pm revealed:<br>-Resident #3's current orders included an order dated 09/13/22 for nitrofurantoin 100mg, one capsule on Mondays, Wednesdays, and Fridays.<br>-Resident #3's medications were dispensed to the facility weekly in multidose packaging.<br>-Nitrofurantoin 100mg, 3 capsules was last dispensed to the facility on 08/11/23.<br>-The pharmacy received Resident #3's FL2 dated 04/04/23 that did not contain an order for nitrofurantoin.<br>-The pharmacy did not discontinue medications unless they received a discontinue order from a provider.<br>-It was the facility's responsibility to clarify the nitrofurantoin order with Resident #3's Primary Care Provider (PCP).<br><br>Interview with the Administrator on 08/16/23 at 5:07pm revealed Resident #3's FL2 dated 04/04/23 should have been clarified with her | D 344 | | |

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Primary Care Provider (PCP) since some medications she was receiving prior to her hospitalization were not on her re-admission FL2.

Refer to the interview with a MA on 08/16/23 at 12:15pm.

Refer to the interview with the Administrator on 08/16/23 at 5:07pm.

b. Review of Resident #3's signed physician's orders dated 02/20/23 revealed an order for chlorthalidone 25mg (a medication to treat high blood pressure), one-half tablet daily.

Review of Resident #3's current FL2 dated 04/04/23 revealed there was no order for chlorthalidone.

Review of Resident #3's June 2023 eMAR revealed there was an entry for chlorthalidone 25mg, one-half tablet daily, and there was documentation it was administered daily at 8:00am from 06/01/23 to 06/30/23.

Review of Resident #3's July 2023 eMAR revealed there was an entry for chlorthalidone 25mg, one-half tablet daily, and there was documentation it was administered daily at 8:00am from 07/01/23 to 07/31/23.

Review of Resident #3's August 2023 eMAR revealed there was an entry for chlorthalidone 25mg, one-half tablet daily, and there was documentation it was administered daily at 8:00am from 08/01/23 to 08/15/23.

Observation on 08/16/23 at 8:30am during the medication pass revealed the MA administered chlorthalidone 25mg, one-half tablet to Resident

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| D 344 | Continued From page 7<br>#3.<br><br>Observation on 08/16/23 at 11:36am of medications on hand for Resident #3 revealed:<br>-A 7-day supply of Resident #3's medications were dispensed to the facility on 08/11/23.<br>-Resident #3's medications were dispensed in a multi-dose package that bundled medications together by date and time.<br>-Chlorthalidone 25mg, one-half tablet was included in Resident #3's morning medications.<br><br>Telephone interview with a Pharmacist with the facility's contracted pharmacy on 08/16/23 at 2:10pm revealed:<br>-Resident #3's current orders included an order dated 10/11/22 for chlorthalidone 25mg, one-half tablet daily.<br>-Resident #3's medications were dispensed to the facility weekly in multidose packaging.<br>-Chlorthalidone 25mg, three and one-half tablets (seven day supply) were last dispensed to the facility on 08/11/23.<br>-The pharmacy received Resident #3's FL2 dated 04/04/23 that did not contain an order for chlorthalidone.<br>-The pharmacy did not discontinue medications unless they received a discontinue order from a provider.<br>-It was the facility's responsibility to clarify the chlorthalidone order with Resident #3's PCP.<br><br>Interview with the Administrator on 08/16/23 at 5:07pm revealed Resident #3's FL2 dated 04/04/23 should have been clarified with her PCP since some medications she was receiving prior to her hospitalization were not on her re-admission FL2.<br><br>Refer to the interview with a MA on 08/16/23 at | D 344 | | |

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| D 344 | Continued From page 8<br>12:15pm.<br><br>Refer to the interview with the Administrator on 08/16/23 at 5:07pm.<br><br>c. Review of Resident #3's signed physician's orders dated 02/20/23 revealed an order for losartan 50mg (a medication to treat high blood pressure), one tablet daily.<br><br>Review of Resident #3's current FL2 dated 04/04/23 revealed there was no order for losartan.<br><br>Review of Resident #3's June 2023 eMAR revealed there was an entry for losartan 50mg, one tablet daily, and there was documentation it was administered daily at 8:00am from 06/01/23 to 06/30/23.<br><br>Review of Resident #3's July 2023 eMAR revealed there was an entry for losartan 50mg, one tablet daily, and there was documentation it was administered daily at 8:00am from 07/01/23 to 07/31/23.<br><br>Review of Resident #3's August 2023 eMAR revealed there was an entry for losartan 50mg, one tablet daily, and there was documentation it was administered daily at 8:00am from 08/01/23 to 08/15/23.<br><br>Observation on 08/16/23 at 8:30am during the medication pass revealed the MA administered losartan 50mg one tablet to Resident #3.<br><br>Observation on 08/16/23 at 11:36am of medications on hand for Resident #3 revealed:<br>-A 7-day supply of Resident #3's medications were dispensed to the facility on 08/11/23. | D 344 | | |

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-Resident #3's medications were dispensed in a multi-dose package that bundled medications together by date and time.
-Losartan 50mg, one tablet was included in Resident #3's morning medications.

Telephone interview with a Pharmacist with the facility's contracted pharmacy on 08/16/23 at 2:10pm revealed:
-Resident #3's current orders included an order dated 09/13/22 for losartan 50mg, one tablet daily.
-Resident #3's medications were dispensed to the facility weekly in multidose packaging.
-Losartan 50mg, seven tablets were last dispensed to the facility on 08/11/23.
-The pharmacy received Resident #3's FL2 dated 04/04/23 that did not contain an order for losartan.
-The pharmacy did not discontinue medications unless they received a discontinue order from a provider.
-It was the facility's responsibility to clarify the losartan order with Resident #3's PCP.

Interview with the Administrator on 08/16/23 at 5:07pm revealed Resident #3's FL2 dated 04/04/23 should have been clarified with her PCP since some medications she was receiving prior to her hospitalization were not on her re-admission FL2.

Refer to the interview with a MA on 08/16/23 at 12:15pm.

Refer to the interview with the Administrator on 08/16/23 at 5:07pm.

d. Review of Resident #3's signed physician's orders dated 02/20/23 revealed an order for

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Metamucil (a fiber supplement) 3.4gm, one packet daily.

Review of Resident #3's current FL2 dated 04/04/23 revealed there was no order for Metamucil.

Review of Resident #3's June 2023 eMAR revealed there was an entry for Metamucil 3.4gm, one packet daily, and there was documentation it was administered daily at 8:00am from 06/01/23 to 06/30/23.

Review of Resident #3's July 2023 eMAR revealed there was an entry for Metamucil 3.4gm, one packet daily, and there was documentation it was administered daily at 8:00am from 07/01/23 to 07/31/23.

Review of Resident #3's August 2023 eMAR revealed there was an entry for Metamucil 3.4gm, one packet daily, and there was documentation it was administered daily at 8:00am from 08/01/23 to 08/15/23.

Observation on 08/16/23 at 8:30am during the medication pass revealed the MA administered Metamucil 3.4gm, one packet to Resident #3.

Observation on 08/16/23 at 11:36am of medications on hand for Resident #3 revealed a box of Metamucil, 44 packets was dispensed to the facility on 05/29/23.

Telephone interview with a Pharmacist with the facility's contracted pharmacy on 08/16/23 at 2:10pm revealed:
-Resident #3's current orders included an order dated 03/14/23 for Metamucil 3.4gm one packet daily.

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| WEXFORD HOUSE | 3900 WEXFORD LANE DENVER, NC 28037 |

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-Metamucil 3.4gm, one box containing 44 packets was last dispensed for Resident #3 on 07/07/23.
-The pharmacy received Resident #3's FL2 dated 04/04/23 that did not contain an order for Metamucil.
-The pharmacy did not discontinue medications unless they received a discontinue order from a provider.
-It was the facility's responsibility to clarify the Metamucil order with Resident #3's PCP.

Interview with the Administrator on 08/16/23 at 5:07pm revealed Resident #3's FL2 dated 04/04/23 should have been clarified with her PCP since some medications she was receiving prior to her hospitalization were not on her re-admission FL2.

Refer to the interview with a MA on 08/16/23 at 12:15pm.

Refer to the interview with the Administrator on 08/16/23 at 5:07pm.

e. Review of Resident #3's signed physician's orders dated 02/20/23 revealed an order for ducosate 100mg (a stool softener), one tablet daily.

Review of Resident #3's current FL2 dated 04/04/23 revealed there was no order for ducosate.

Review of Resident #3's June 2023 eMAR revealed there was an entry for ducosate 100mg, one tablet daily, and there was documentation it was administered daily at 8:00am from 06/01/23 to 06/30/23.

Review of Resident #3's July 2023 eMAR

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revealed there was an entry for ducosate 100mg, one tablet daily, and there was documentation it was administered daily at 8:00am from 07/01/23 to 07/31/23.

Review of Resident #3's August 2023 eMAR revealed there was an entry for ducosate 100mg, one tablet daily, and there was documentation it was administered daily at 8:00am from 08/01/23 to 08/15/23, except on 08/04/23 when it was documented as not administered.

Observation on 08/16/23 at 8:30am during the medication pass revealed the MA administered ducosate 100mg, one tablet to Resident #3.

Observation on 08/16/23 at 11:36am of medications on hand for Resident #3 revealed:
-A 7-day supply of Resident #3's medications were dispensed to the facility on 08/11/23.
-Resident #3's medications were dispensed in a multi-dose package that bundled medications together by date and time.
-Ducosate 100mg, one tablet was included in Resident #3's morning medications.

Telephone interview with a Pharmacist with the facility's contracted pharmacy on 08/16/23 at 2:10pm revealed:
-Resident #3's current orders included an order dated 09/14/22 for ducosate 100mg, one tablet daily.
-Resident #3's medications were dispensed to the facility weekly in multidose packaging.
-Ducosate 100mg, seven tablets were last dispensed to the facility on 08/11/23.
-The pharmacy received Resident #3's FL2 dated 04/04/23 that did not contain an order for ducosate.
-The pharmacy did not discontinue medications

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unless they received a discontinue order from a provider.
-It was the facility's responsibility to clarify the ducosate order with Resident #3's PCP.

Interview with the Administrator on 08/16/23 at 5:07pm revealed Resident #3's FL2 dated 04/04/23 should have been clarified with her PCP since some medications she was receiving prior to her hospitalization were not on her re-admission FL2.

Refer to the interview with a MA on 08/16/23 at 12:15pm.

Refer to the interview with the Administrator on 08/16/23 at 5:07pm.

2. Review of Resident #4's current FL2 dated 08/07/23 revealed:
-A diagnosis of neuropathy, diabetes mellitus, hyperlipidemia, high blood pressure and paranoid schizophrenia.
-An order for gabapentin (a medication used to treat nerve pain or anticonvulsant therapy) 300mg take 1 capsule by mouth 3 times a day.
-A second order for gabapentin 300mg take 3 capsules 3 times a day.

Review of Resident #4's Resident Register revealed Resident #4 was admitted to the facility on 08/10/23.

Review of Resident #4's August 2023 electronic medication administration record (eMAR) revealed:
- An entry to send clarification for gabapentin 300mg, how many capsules is she taking (1 or 3) written both ways on medication list.
-On 08/14/23, there was documentation the

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gabapentin was not administered because the medication required clarification.
-On 08/15/23, there was documentation the gabapentin was not administered because the medication required clarification.

Review of the facility's receipt of medication form dated 8/10/23 revealed gabapentin 300mg with a quantity of 246 tablets was received from Resident #4.

Observation of Resident #4's medications on hand for administration on 08/15/23 at 4:00pm revealed a full bottle with approximately 135 capsules, labeled gabapentin 300mg, take 2 capsules three times a day, with a dispense date of 07-17-23.

Review of facilities medication clarification sheets on 08/16/23 revealed there was no clarification sheet completed for Resident #4.

Interview with a MA on 08/16/23 at 12:15pm revealed:
-The Resident Care Coordinator (RCC) and the Administrator were responsible for faxing the FL2 or physician orders to the pharmacy.
-The MAs were responsible for faxing the FL2 or physician orders to the pharmacy if the RCC and the Administrator were not available.
-The MAs, RCC and the Administrator were responsible for faxing the facility's medication clarification sheet to the physician for clarification of any orders in question.
-Resident #4 brought gabapentin from home upon admission.
-She compared the label on Resident #4's gabapentin from home with the physician orders and they did not match.
-She faxed the FL2 to the pharmacy and the

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pharmacy entered the orders as profile only because Resident #4 brought medications from home.
-On 08/14/23 and 08/15/23, she did not administer the gabapentin because the orders were not clarified yet.
-On 08/14/23 and 08/15/23, she did not call or fax the medication clarification order sheet to the physician because she knew Resident #4 would see the PCP on 08/16/23.

A telephone interview with a representative from Resident #4's Primary Care Physician (PCP) office on 8/16/23 at 2:13 PM revealed:
-Resident #4 was still an active patient and last seen on 08/07/23.
-No communication regarding clarification of the medication order for gabapentin related to Resident #4, was received from the facility.
-It was the facility's responsibility to notify the PCP's office to clarify orders.

An attempted telephone interview on 08/16/23 at 2:13pm with Resident #4's PCP was unsuccessful.

A telephone interview with Resident #4's pharmacy on 08/16/23 at 2:42pm revealed:
-A fax was received on 08/07/23 from Resident #4's PCP and placed on hold.
-An Electronic prescription (ERx)for gabapentin 300mg, 3 capsules three times a day was put on hold because it was previously filled on 07/17/23.
-There were no calls documented as received from the facility to clarify orders or send new orders as of 08/16/23 at 2:42pm.

A telephone interview with the facilities contracted pharmacy on 08/16/23 at 2:53pm revealed:
-On 08/09/23, the pharmacy received the FL2

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dated 08/07/23.
-The gabapentin could not be entered into the eMAR because the gabapentin order required clarification.
-On 8/11/23, the pharmacy entered a note in the eMAR with a question to clarify the gabapentin order.
-No communication was received from the facility regarding the medication orders prior to 08/16/23.
-It was the facility's responsibility to clarify the orders.

Interview with the facilities Nurse Practitioner (NP) on 08/16/23 at 9:00am revealed:
-On 08/16/23, was the first visit with Resident #4.
-Resident #4's FL2 dated 08/07/23 contained two different orders for gabapentin which required clarification.
-She was not the provider at the time of admission, and she did not write the orders on the FL2, so the facility should have contacted Resident #4's previous PCP for clarification.

Telephone interview with Resident #4's guardian on 08/16/23 at 4:47pm revealed:
-Resident #4's previous PCP wrote the orders on the FL2 dated 08/07/23.
-She was aware Resident #4 was to see the facilities NP on 08/16/23.

Interview with Resident #4 on 08/16/23 at 5:00pm revealed her legs were hurting, and she told the NP on 8/16/23 visit.

Interview with the Administrator on 8/16/23 revealed:
-She and the RCC are responsible for clarification of medication orders.
-She and RCC were responsible for faxing the pharmacy and clarification of orders to the

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| D 344 | Continued From page 17<br>primary care physician.<br>-The MAs could fax clarifications if she or the RCC were not available.<br><br>Interview with a MA on 08/16/23 at 12:15pm revealed:<br>-The Resident Care Coordinator (RCC) or the Administrator were responsible for faxing resident FL2s and new orders to the pharmacy.<br>-The staff member responsible for sending orders to the pharmacy was responsible for getting clarification of orders from the PCP if necessary.<br><br>Interview with the Administrator on 08/16/23 at 5:07pm revealed she and the RCC were responsible for clarification of residents' orders. | D 344 | **"Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law."** | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 residents (Resident #1) to help lower mealtime and bedtime blood sugar spikes.<br><br>Review of Resident #1's current FL2 dated 07/15/23 revealed diagnoses included type 2 | D 358 | 10A NCAC 13F .1004(a) Medication Administration<br>The Executive Director will review the rule area listed above with the Resident Care Coordinator to ensure proper requirements are understood and processes are in place to prevent further non compliance.<br><br>The Executive Director, Resident Care Coordinator will retrain all necessary core staff members (Med Aides/SICS) on the Rule Area stated above ensuring all medication orders are prepared and administered accurately and in accordance to orders provided by PCP/LHP.<br><br>Resident Care Coordinator/Med Aides/SICs will receive in-servicing on the importance of administering medications to include insulin/sliding scale accurately according to written orders by PCP/LHP and report any Medication Errors to RCC/ED. Facility will then ensure all Medication errors are reported to PCP and documentation of error and orders to follow will be documented in the Resident's electronic health record.<br><br>Resident Care Coordinator will conduct daily to weekly audits to ensure rule area is being met. Any non compliance will be immediately addressed and any necessary staff will be retrained and in serviced on proper techniques for Medication Administration<br><br>Area Clinical Director will conduct on site visits Med Aide/ SIC medication administration audits to ensure Medication Administration is followed accurately and will provide immediate retraining for any non compliance found during Medication Administration audit. | 10/31/2023 |

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diabetes mellitus and hyperlipidemia.

Review of Resident #1's signed PCP (primary care provider) orders dated 06/27/23 revealed an order for Humalog KwikPen Insulin inject four times daily before meals and at bedtime per sliding scale: FSBS (finger stick blood sugar): 70-150 =0 units, 151-200 = 4 units, 201-250 = 6 units, 251-300 = 8 units, 301-350 = 10 units, 351-400 = 12 units, greater than 400, call PCP.

Review of Resident #1's July 2023 electronic medication administration record (eMAR) revealed:
-There was an entry dated 05/03/23 to check FSBS four times daily at 7:00am, 11:30am, 5:00pm and 9:00pm and administer Humalog per sliding scare four times a day: FSBS: 70-150 =0 units, 151-200 = 4 units, 201-250 = 6 units, 251-300 = 8 units, 301-350 = 10 units, 351-400 = 12 units, greater than 400, call PCP.
-On 07/31/23 at 11:30am, the resident's FSBS was 164 and the resident received 0 units of insulin when the order stated she should have received 4 units.
-On 07/31/23 at 5:00pm, the resident's FSBS was 162 and the resident received 0 units of insulin when the order stated she should have received 4 units.
-On 07/31/23 at 9:00pm, the resident's FSBS was 200 and the resident received 0 units of insulin when the order stated she should have received 4 units.

Review of Resident#1's August 2023 eMAR revealed:
-There was an entry dated 07/31/23 to check FSBS four times daily at 7:00am, 11:30am, 5:00pm and 9:00pm and administer Humalog per sliding scare four times a day: FSBS: 70-150 =0

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units, 151-200 = 4 units, 201-250 = 6 units, 251-300 = 8 units, 301-350 = 10 units, 351-400 = 12 units, greater than 400, call PCP.
-On 08/04/23 at 7:00am, the resident's FSBS was 194 and the resident received 2 units of insulin when the order stated she should have received 4 units.

Interview with the Area Clinical Director (ACD) on 08/15/23 at 11:30am revealed:
-The RCC (resident care coordinator) was responsible for the eMAR audits.
-EMAR audits were completed weekly.
-The RCC did cart audits weekly.
-The Administrator did cart checks weekly.

Interview with a medication aide (MA) on 08/16/23 at 2:35pm revealed:
-She checked FSBS prior to giving sliding scale insulin on Resident #1.
-She received training on FSBS and sliding scale insulin during her orientation when she was hired at the facility.
-The MAs did cart audits monthly if they had the time.
-The eMAR had a space to put in the FSBS and the sliding scale order was visible, but the MA had to check which sliding scale to use per the FSBS.
-She had never been told she made any errors on sliding scale insulin.

Interview with a Pharmacist with the facility's contracted pharmacy on 08/16/23 at 4:20pm revealed:
-The sliding scale insulin order was to be administered 4 times a day at 7:00am, 11:30am, 5:00pm and 9:00pm for FSBS: 70-150 = 0 units, 151-200 = 4 units, 201-250 = 6 units, 251-300 = 8 units, 301-350 = 10 units, 351-400 = 12 units and if over 400 call PCP.

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| D 358 | Continued From page 20<br>-On 06/27/23, and 08/09/23, 5 Humalog Kwik Pens were dispensed to the facility.<br>-If the resident did not receive the sliding scale insulin, her blood sugars could have become high, which could eventually damage kidneys and blood vessels.<br><br>Interview with the Administrator on 08/16/23 at 3:10pm revealed:<br>-The RCC audited the eMARs weekly.<br>-The RCC randomly chose at least 3 residents a week and checked the eMARs against physician orders.<br>-The Pharmacy placed the orders on the eMARs and the RCC or Administrator verified the accuracy.<br>-The Administrator was not aware Resident #1 did not receive her sliding scale insulin on 07/31/23 at 11:30am, 5:00pm and 9:00pm.<br>-The Administrator was not aware Resident #1 received an incorrect does of sliding scale insulin on 08/04/23 at 7:00am.<br>-She would expect the MA to administer sliding scale insulin correctly.<br><br>Telephone interview with a second MA on 08/16/23 at 3:05pm was unsuccessful.<br><br>Telephone interview with resident #1's PCP on 08/16/23 at 3:45pm was unsuccessful. | D 358 | | |