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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 05/11/17 - 05/12/17.	{D 000}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure health care needs were met for 2 of 5 sampled residents (#1, #3) as related to failure to contact the primary care provider (PCP) for a resident (#3) with multiple refusals of insulin administration and failure to notify the PCP of high blood sugars; and failure to contact the PCP for a resident (#1) with refusals of ten medications scheduled for 8:00 a.m. for 10 out of 11 days in May 2017. The findings are: Review of the facility's written policy for medication refusals revealed: -If a resident refused a medication for 3 consecutive doses, the facility would notify the primary care provider (PCP). -The facility would ask the PCP if the medication should be discontinued at that time or should the facility continue to offer the refused medication. -The facility staff should document the PCP's response in the nursing notes and write a telephone order in the resident's record.	{D 273}		

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{D 273}	Continued From page 1 1. Review of the current FL-2 dated 2/13/17 for Resident #3 revealed: - Diagnoses included Diabetes Mellitus Type I, urinary tract infections, pneumonia with acute respiratory failure, and anemia. - There was an order for finger stick blood sugar (FSBS) checks four times per day with Humalog insulin sliding scale of 0 - 150 0 units; 151 - 199 1 unit; 200 - 249 2 units; 250 - 299 3 units; 300 - 399 5 units. (Humalog insulin is a fast acting meal time insulin to control blood sugar.) - There was an order for Lantus 10 units subcutaneously (SQ) at bedtime. (Lantus is a slow acting insulin used between meals and over night to control blood sugar. Review of a subsequent order for insulin dated 3/12/17 fro Resident #3 revealed Humalog 10 units for sliding scale of equal to (=) or greater than (>) 400 and call the physician. Review of the Resident Register for Resident #3 revealed an admission date of 2/17/17. Interview on 5/12/17 at 12:09 p.m. with Resident #3 revealed: - He was a diabetic, took insulin and got fingerstick blood sugar (FSBS) checks. - He sometimes refused his insulin and FSBS checks because he was afraid of "bottoming out" with insulin. - He explained his symptoms when "bottoming out" with insulin as a shaky cold feeling. - He would at times request the medication aide (MA) to give him less of the prescribed insulin dose to prevent the symptoms. - He had not been sent to the hospital for any high or low FSBS checks since admission to the facility.	{D 273}		

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{D 273}	Continued From page 2 - He thought his insulin reactions were less of a concern now. A. Humalog insulin per sliding scale administration and FSBS refusals were as follows: Review of the Medication Administration Record (MAR) for Resident #3 dated March 17 - 31, 2017, documentation of Humalog 100u/ml insulin per sliding scale refusals revealed: - Five consecutive insulin refusals were documented with FSBS at 6:30 a.m. on 3/18/17 - 174, 3/19/17 - 350, 3/20/17 - 181, 3/21/17 - 332, and 3/22/17 - 283. - Five consecutive insulin refusals at 6:30 a.m. were documented with FSBS on 3/25/17 - 294, 3/26/17 - 218, 3/27/17 - 188, 3/28/17 - 276, 3/29/17 - 163, - An insulin refusal with a FSBS at 6:30 a.m. on 3/31/17 - 238. - Three insulin refusals were documented at 11:30 a.m. on 3/18/17 - 141, 3/20/17 - 249 and 3/31/17 - 376. - Five insulin refusals were documented with FSBS at 4:30 p.m. on 3/17/17 - 291, 3/19/17 - 228, 3/25/17 - 316, 3/26/17 - 198, and 3/30/17 - 241. - FSBS refusals were documented at 4:30 p.m. on 3/20/17, 3/24/17, and 3/29/17. - Refusals of insulin were documented with FSBS at 9:30 p.m. on 3/18/17 - 164, 3/19/17 - 220, 3/21/17 - 186, 3/22/17 - 297, 3/23/17 - 294, 3/24/17 - 251, 3/27/17- 386, 3/28/17 - 291, and 3/30/17 - 322. Review of the March 2017 MAR and resident care notes for Resident #3 revealed there was no documentation of contact with the PCP about multiple refusals of Humalog insulin and FSBS	{D 273}		

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{D 273}	Continued From page 3 checks. Review of the April 2017 MAR of Resident #3 for Humalog 100u/ml insulin per sliding scale and FSBS refusals revealed: - Seven insulin refusals were documented with FSBS at 6:30 a.m. on 4/01/17 - 286, 4/02/17 -235, 4/06/17 - 223, 4/08/17 - 305, 4/13/17 - 294, 4/14/17 - 234, and 4/20/17 - 306, - Four insulin refusals with FSBS were documented at 11:30 a.m. on 4/07/17 - 264, 4/23/17 - 201, 4/29/17 - 262, and 4/30/17 - 206. - Two FSBS refusals were documented at 11:30 a.m. on 4/08/17 and 4/27/17. - Eight insulin refusals with FSBS were documented at 4:30 p.m. on 4/01/17 - 471, 4/05/17 - 276, 4/17/17 - 293, 4/20/17 - 214, 4/21/17 - 459 and 4/28/17 - 254. - Two FSBS were refused at 4:30 p.m. on 4/14/17 and 4/19/17. - Refusal of insulin with FSBS at 9:30 p.m. on 4/01/17 - 383, 4/03/17 - 453, 4/05/17 - 449, 4/06/17 - 380, 4/07/17 - 263, 4/08/17 - 320, 4/09/17 - 321, 4/12/17, - 325, 4/21/17 - 251, 4/24/17 - 271, 4/25/17 - 212, and 4/29/17 - 212. - One FSBS was documented refused on 4/28/17. Review of the April 2017 MAR and resident care notes for Resident #3 revealed there was no documentation of contact with the PCP about the multiple refusals of Humalog insulin and FSBS checks. Review of the MAR for May 1, 2017 - May 12, 2017 for Resident #3's Humalog 100u/ml insulin per sliding scale and FSBS check refusals revealed: - Five insulin refusals with FSBS were documented at 6:30 a.m. on 5/01/17 - 298 and	{D 273}		

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{D 273}	Continued From page 4 5/10/17. - Three of the FSBS and insulin were refused at 6:30 a.m. on 5/05/17, 5/06/17 and 5/11/17. - Four insulin refusals were documented at 11:30 a.m. on 5/06/17 - 447, 5/07/17 - 203, 5/08/17 - 162 and on 5/11/17 - 369. - One FSBS with possible insulin was refused on 5/05/17 at 11:30 a.m. - Insulin refusals were documented at 4:30 p.m. on 5/01/17 - 479, 5/07/17 - 253, 5/09/17 - 337, 5/10/17 - 404. - Five FSBS refusals were documented at 4:30 p.m. on 5/03/17 - 5/06/17 and 5/11/17. - Ten insulin refusals were documented at 9:30 p.m. from 5/02/17 - 136, 5/03/17 - 519, 5/04/17 - 212, 5/09/17 - 232, 5/10/17 - 542. - Five FSBS and insulin refusals were documented at 9:30 p.m. on 5/05/17 - 5/08/17 and 5/11/17. Review of the May 2017 MAR and resident care notes for Resident #3 revealed there was no documentation of contact with the PCP about the multiple refusals of Humalog insulin and FSBS checks. B. Review of Medication Administration Records (MAR) with Lantus 10 units SQ for Resident #3 for March 2017, April 2017 and May 2017 were as follows: Review of the refusals from 3/17/17 - 3/31/17 MAR for Lantus 10 units SQ in the evening revealed: - Nine consecutive refusals were documented at 5 p.m. from 3/17/17 - 3/25/17. - Four consecutive refusals were documented at 5 p.m. from 3/27/17 - 3/30/17. Review of the March 2017 MAR and care notes	{D 273}		

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{D 273}	Continued From page 5	{D 273}		

for Resident #3 revealed there was no documentation of contact with the PCP about the multiple refusals of Lantus insulin.

Review of the refusals for the April 2017 MAR for Resident #3's Lantus 10 units SQ in the evening revealed refusals were documented at 5 p.m. on 4/01/17, 4/03/17, 4/05/17 - 4/08/17, 4/10/17, 4/12/17, 4/14/17 and 4/15/17, 4/17/17, 4/19/17 - 4/22/17, 4/24/17 - 4/30/17.

Review of the April 2017 MAR and care notes for Resident #3 revealed there was no documentation of contact with the PCP about the multiple refusals of Lantus insulin.

Review of the refusals for the May 2017 MAR of Resident #3 for Lantus 10 units SQ in the evening revealed refusals of Lantus insulin were documented at 5 p.m. from 5/01/17 - 5/11/17.

Review of the May 2017 MAR and care notes for Resident #3 revealed there was no documentation of contact with the resident's PCP about the multiple refusals of Lantus insulin.

C. Review of Resident #3's record and medication administration records (MAR) for primary care provider (PCP) notification of FSBS equal to (=) or greater than (>) 400 revealed the following:

Review of the March 2017 resident care notes and MAR for Resident #3 at 6:30 a.m. from 3/17/17 - 3/31/17 included on 3/19/17 - 441 and on 3/30/17 - 462 at 11:30 a.m., had no documentation of contact with the resident's PCP.

Review of the April 2017 resident care notes and 2017 MAR for Resident #3 revealed:

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{D 273}	Continued From page 6	{D 273}		

4 out of 12 times, the PCP was not contacted when the FSBS was = or > 400 at 6:30 a.m. on 4/16/17 - 495, 4/26/17 - 449, 4/29/17- 466 and 4/30/17 - 501.

Review of the April 2017 resident care notes and 2017 MAR for Resident #3 revealed 3 out of 3 times the PCP for Resident #3 was not contacted when the FSBS was = or > 400 of at 11:30 a.m. on 4/06/17 - 435, 4/11/17 - 471, and 4/12/17 - 410.

Review of the April 2017 resident care notes and April 2017 MAR revealed 3 of 5 times when the FSBS was = or > 400 at 4:30 p.m. revealed FSBS on 4/01/17 - 471, 4/21/17 - 459, and 4/27/17 - 491 with no documentation of contact with the resident's PCP.

Review of the April 2017 resident care notes and 2017 MAR for Resident #3 revealed 6 of 6 times when the FSBS was = or > 400 at 9:30 p.m. on 4/03/17 - 453, 4/05/17 - 449, 4/11/17- 469, 4/17/17 - 531, 4/19/17 - 550, 4/27/17 - 500 there was no documentation of contact with the resident's PCP.

Review of the May 2017 resident care notes and 2017 MAR for Resident #3 revealed when the FSBS was = or > 400 at 11:30 a.m. on 5/06/17 - 447 there was no documentation of contact with the PCP.

Review of the May 2017 resident care notes and May 2017 MAR, revealed 2 of 2 times when the FSBS was = or > 400 at 4:30 p.m. on 5/01/17 - 479, 5/10/17 - 404, and there was no documentation of contact with the resident's PCP.

Review of the May 2017 resident care notes and

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{D 273}	Continued From page 7 MAR revealed, 2 of 2 times when the FSBS was = or > 400 at 9:30 p.m. on 5/03/17 - 519, and 5/10/17 - 542 and there was no documentation of contact with the PCP. Interview on 5/12/17 at 10:30 a.m. with the Resident Care Manager (RCM) revealed: - The PCP knew about Resident #3's refusals of insulin because the MAR went with each resident to physician visits. - She was sure the PCP had seen the FSBS. Interview with the RCM on 05/12/17 at 11:42 a.m. revealed: -When a resident went to a physician's visit, the facility usually sent a copy of the resident's physician's order sheet which listed the resident's medications. -The facility did not send copies of the resident's MARs when they went to a physician's visit. Interview on 5/12/17 at 3:10 p.m. with the RCM revealed: - The medication aide (MA) should report medication refusals according to the facility policy. - Refusals should be reported to the physician for guidance when the third refusal occasion occurred. - A MA had received a new order for additional Humalog insulin dose for FSBS over 400. - She was aware Resident #3 had been refusing both types of his insulin. - She was not aware the MA staff had not been notifying the physician's office with all of the refusal occasions according to policy. - There was some documentation for the refusal notifications to the physician in the record. - There was not a system to review the records of residents to ensure notification of refusals per	{D 273}		

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{D 273}	Continued From page 8 policy had been completed by the MAs. Interview on 5/12/17 at 4 p.m. with Resident #3's primary care provider (PCP) revealed: - She was not aware of any contacts from the facility regarding multiple refusals of the resident's two types of insulin. - She did not have the resident's record available at this time, but would check the record for contact documentation and forward any documentation found. - Had she known about the multiple refusals she would have tried to work with the resident on insulin dosing and changes in routes of administration and use of other medications to lower blood sugar. - She was very concerned with the elevated finger stick blood sugar checks for the resident. - If refusals were to continue the resident would be a risk for diabetic complications. - At this point the resident should be evaluated for his blood sugar and insulin refusals and the high FSBS. - If the resident continued to refuse in the next two days, the facility should call for an appointment for the resident to be seen. - She thought it would be alright to reduce the amount of insulin when the resident refused but to try to get him to take the largest amount of the prescribed dose as possible. - It may reassure the resident to take the whole prescribed dose and recheck the FSBS level to ensure blood sugar is not too low. - The facility should follow their policy and call with refusals. Interview on 5/12/17 at 4:15 p.m. with a medication aide (MA) revealed: - She had worked in the facility as a medication aide and a supervisor.	{D 273}		

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{D 273}	Continued From page 9 - Resident #3 had been admitted in late February of 2017 and was a diabetic. - The resident was administered two types of insulin, one sliding scale and one routine insulin in the evening. - He had been refusing multiple doses of all of his insulin since admission. - She had notified the physician when the FSBS were 400 or greater and the physician wrote an order for Humalog 10 units SQ and to call with the elevated FSBS in March 2017. - MAs were to call for refusals every 3rd time of refusal. - She had called the physician with most of the refusals. - She may not have documented notification of all of the refusals noted on the MARs in March 2017 and April 2017. Interview on 5/12/17 at 4:25 p.m. with a second MA revealed: - The MA had administered insulin to Resident #3. - The resident had many refusals especially with the evening longer acting insulin, Lantus. - The policy to report refusals, in this facility, was to notify with every third refusal she received from the resident. - Notification was to be completed after every three refusals for each individual MA rather than every third refusal no matter which MA. - When asked about there being no documentation in the resident's record of the Lantus, Humalog and FSBS refusals in March 2017, April 2017 and May 2017, she thought she had documented contact in the resident's record. Interview on 5/12/17 at 4:35 p.m. with a third MA revealed: - Resident #3 had many refusals of insulin.	{D 273}		

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{D 273}	Continued From page 10 - She had notified the PCP on call in April 2017 and May 2017 at 6:30 a.m. about FSBS over 400 and had documented them in the record. - Refusals, according to policy, was notification should take place after every third refusal time. - When questioned about there not being documentation of the frequent refusals of insulin and FSBS checks by Resident #3, the MA was not sure if all of the refusals circled on the MAR had been called to the physician. - The MA's were to document on the MAR with a circle and then write in the care notes any notifications. - She thought she had documented the refusals by the resident and it should be in the resident's record. No other PCP refusal notification documentation for Resident #3 was provided by the facility by the end of the survey. 2. Review of Resident #1's current FL-2 dated 05/02/17 revealed: -The resident's diagnoses included diabetes mellitus, chronic obstructive pulmonary disease, hypothyroidism, paranoid schizophrenia, bipolar disorder, mild intellectual disabilities, gastroesophageal reflux disease, general muscle weakness, and unsteadiness on feet. -There was an order for Lasix 20mg once daily. (Lasix is a diuretic.) -There was an order for Spiriva inhale contents of 1 capsule (2 inhalations) once daily. (Spiriva is used to treat chronic obstructive pulmonary disease.) -There was an order for Keppra 500mg twice a day. (Keppra may be used to treat mood disorders.) -There was an order for Prilosec 20mg once a day. (Prilosec used to treat acid reflux.)	{D 273}		

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{D 273}	Continued From page 11 -There was an order for Pravachol 10mg once daily. (Pravachol is used to lower cholesterol.) -There was an order for Vitamin D3 5,000 units once daily. (Vitamin D3 is used to treat Vitamin D deficiency.). -There was an order for Zinc Sulfate 220mg once daily. (Zinc Sulfate is a mineral supplement.) -There was an order for Vitamin C 500mg twice daily. (Vitamin C is a vitamin supplement.) Review of physician's orders dated 05/08/17 for Resident #1 revealed: -There was an order for Breo Ellipta 100mcg/25mcg disk, inhale 1 puff daily. (Breo Ellipta is used to treat chronic obstructive pulmonary disease and asthma.) -There was an order for ProAir inhale 2 puffs every 4 hours. (ProAir is used to treat wheezing and shortness of breath.) Review of Resident #1's Resident Register revealed he was admitted to the facility on 03/13/17. Interview with Resident #1 on 05/11/17 at 10:58 a.m. revealed: -He refused his medications today on 05/11/17. -He did not give a reason for refusing his medications. -Sometimes he took his medications and sometimes he did not take them. -He did not know if his primary care provider (PCP) was aware he refused his medications. Review of Resident #1's May 2017 medication administration record (MAR) revealed: -There was an entry on the MAR for Lasix, Spiriva, Keppra, Prilosec, Pravachol, Vitamin D3, Zinc Sulfate, Vitamin C, Breo Ellipta, and ProAir that matched the current orders.	{D 273}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 12 -Lasix, Spiriva, Prilosec, Pravachol, Vitamin D3, Zinc Sulfate, and Breo Ellipta were all scheduled to be administered once daily at 8:00 a.m. -Keppra and Vitamin C were both scheduled to be administered at 8:00 a.m. and 8:00 p.m. -ProAir was scheduled to be administered at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. -The 8:00 a.m. doses for all 10 of these medications were documented as refused by the resident for 10 out of 11 days so far in May 2017 (05/01/17 - 05/04/17 and 05/06/17 - 05/11/17). -The Keppra was also refused at 8:00 p.m. on 05/09/17. -The Vitamin C was also refused at 8:00 p.m. on 05/02/17, 05/04/17, and 05/06/17 - 05/09/17. -The ProAir was also refused on at 12:00 p.m. and 4:00 p.m. on 05/01/17, 05/02/17, and 05/10/17 making 3 consecutive doses on each of those days. -The ProAir was refused on four consecutive doses on 05/09/17. Review of Resident Care Notes for Resident #1 revealed: -04/11/17: The resident refused morning medications. -04/18/17: The resident refused morning medications twice in one week (8:00 a.m. meds). They would continue to monitor and document as needed. They would also contact the PCP if the refusals continued. -05/05/17: The resident had been very belligerent and uncooperative with staff. On occasion, he refused his morning medications. They would continue to monitor the resident closely. -05/06/17: The resident refused morning medications. -05/11/17: The resident had refused his medications for the last few days. When he was asked if he was taking his medications, the	{D 273}		

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{D 273}	Continued From page 13 resident responded by saying "ugly words". Review of Resident #1's Care Notes revealed no documentation that the primary care provider (PCP) had been notified of Resident #1's medication refusals. Interviews with a medication aide (MA) on 05/11/17 at 11:59 a.m. and 3:00 p.m. revealed: -Resident #1 refused his medications frequently. -Resident #1 had refused his medications for the last few days. -Resident #1 had only taken his morning medications for 1 out of the last 5 days when she was working. -She thought the facility's policy was to contact the PCP when a resident refused medications for 3 days in a row. -She had not contacted Resident #1's PCP and gave no reason why she had not contacted the PCP. -Resident #1 refused medications from other MAs as well. Interview with a second MA on 05/12/17 at 8:40 a.m. revealed: -If a resident refused any medication at least 3 times, whether consecutive doses or not, the MAs were supposed to call the PCP and document it in the care notes. -She was aware Resident #1 refused his medications frequently. -She had not contacted Resident #1' PCP because the resident had not refused with her 3 times. -If Resident #1 refused his medications again this morning (05/12/17), she would call the PCP because he had refused two other times with her. Interview with a third MA on 05/12/17 at 11:20	{D 273}		

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{D 273}	Continued From page 14 a.m. revealed: -Resident #1 refused medications when he could not get cigarettes. -The facility's policy was to notify the primary care provider (PCP) of refusals after the medication had been refused for 2 days. -The MAs were supposed to document notification of the physician in the care notes. -She had not contacted Resident #1's PCP about any refusals. Interview with the Resident Care Manager (RCM) on 05/12/17 at 11:42 a.m. revealed: -She usually reviewed the MAR exceptions reports on Monday or Tuesday each week where refusals were documented. -She thought the facility's policy was to contact the PCP after 3 days of refusals. -The MAs should contact the PCP about the refusals and document in the resident care notes. -She was aware Resident #1 had refused his morning medications in May 2017. -She did not know if the MAs had contacted Resident #1's PCP about the medication refusals. -She had not contacted the PCP about the refusals. -Resident #1 refused his 8:00 a.m. medications. -She did not recall seeing the facility's written policy for medication refusals before today, 05/12/17. -She would contact Resident #1's PCP today about the refusals. Telephone interview with Resident #1's primary care provider (PCP) on 05/12/17 at 10:55 a.m. revealed: -She had not been notified of any medication refusals for Resident #1. -She expected the facility to notify her of medication refusals in accordance with the	{D 273}		

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{D 273}	Continued From page 15 facility's policy. -She was especially concerned about the resident missing doses of his inhalers because during her last visit with the resident, he was having difficulty breathing and she changed some of his inhalers. -She was also concerned that the resident was missing doses of his medication for mood disorder which could contribute to the refusals. Interview with the RCM on 05/12/17 at 11:45 a.m. revealed: -She spoke with the PCP about Resident #1's medication refusals. -They moved up Resident #1's next appointment to 05/15/17 at 11:15 a.m. Interview with Resident #1 on 05/12/17 at 1:05 p.m. revealed: -He got short of breath when he moved around. -The inhalers helped when he used them. -He did not think he had any inhalers to use anymore. -He denied any shortness of breath currently while sitting in his wheelchair. Interview with the RCM on 05/12/17 at 3:37 p.m. revealed: -Resident #1 got short of breath when he moved around. -Resident #1 had shortness of breath and was breathing fast and hard when she helped him change his clothes that morning on 05/12/17. _____ The facility failed to notify Resident #3's primary care provider (PCP) of multiple refusals of two types of insulin from 03/17/17 - 05/11/17 resulting in elevated blood sugar levels and the facility failed to notify the PCP of blood sugars greater than or equal to 400. The facility failed to notify	{D 273}		

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{D 273}	Continued From page 16 Resident #1's PCP of refusals to take all 10 medications scheduled to be administered at 8:00 a.m. on 10 out of 11 days in May 2017, including 3 inhalers used to treat and prevent symptoms of chronic obstructive pulmonary disease resulting in the resident continuing to have issues with shortness of breath upon exertion. The failure of the facility to notify the PCP according to the facility's refusal policy and the order was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. Review of the facility's plan of protection dated 05/12/17 revealed: -The Regional Director of Operations (RDO) and Resident Care Manager (RCM) will review policy for medication refusals with all medication aides (MAs) starting on 05/12/17. -A copy of the policy will be given to the MAs to sign acknowledging receipt and understanding of the policy. -The RCM notified physician of refusals for sampled residents identified during the survey. -In the event a resident refuses medications for 3 consecutive doses, the MA will notify the primary physician via fax and follow-up with a phone call during business hours. -MAs will also notify the physician when parameters are out of range for physician's orders. -The MAs will communicate with the RCM of refusals and out of range parameters and notify the physician. -The RCM will review and monitor resident refusals to follow-up with physician weekly. -This will be documented in a physician communication log. -The RCM will also review and monitor out of range parameters to follow-up with physician.	{D 273}		

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{D 273}	Continued From page 17 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 26, 2017.	{D 273}		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure medication orders, that were not clear or complete on admission, including medications for hypertension, gastro-esophageal reflux, edema, and benign prostatic hypertrophy were verified with the resident's physician and documented in the resident's record for 1 of 5 sampled residents (#3). The findings are: Review of the current FL-2 dated 2/13/17 for Resident #3 revealed:	D 344		

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D 344	Continued From page 18 - Diagnoses included Diabetes Mellitus Type I, urinary tract infections, pneumonia with acute respiratory failure, anemia, inflammatory disorder of the scrotum, abscess of the epididymis and testis. - Medication orders on the FL-2 included Norvasc 10mg daily. (Used to treat hypertension.); Lasix 40mg daily. (Used as a diuretic for edema.); KDur 20meq daily. (A potassium chloride replacement supplement when used with a diuretic.); Aspirin 81mg daily. (Used to reduce the risk of blood clots.); Proscar 5mg daily. (Used to treat prostatic hypertrophy.); Protonix 40mg daily. (Used to treat gastro-esophageal reflux disorder.) Review of the current Resident Register for Resident #3 revealed an admission date of 2/17/17. Review of the Medication Administration Records (MAR) for March 2017, April 2017 and May 2017 for Resident #3 revealed: - Norvasc, Lasix, KDur, Aspirin, Proscar and Protonix on the current FL-2 dated 2/13/17 were not listed listed for administration for these months. Review of Resident #3's medications on hand revealed the medications on the current FL-2 and not listed for administration on the MAR were not available on hand for administration. Review of the record for Resident #3 revealed there was no documentation the facility had verified the missing medications ordered on the current FL-2 had been verified by the facility upon admission Interview on 5/12/17 at 12:40 p.m. with the	D 344		

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D 344	Continued From page 19	D 344		

Resident Care Manager (RCM) revealed:
- Resident #3 had been admitted from skilled nursing facility with the current FL-2.
- There were unsigned medication list forms from the resident's previous facility that agreed with the current MAR list of medications for administration.
- Typically, the current FL-2 orders were faxed to the pharmacy.
- She was sure the medications listed on the MAR for administration were the current medications to be administered since the pharmacy was listing them on the electronic MAR.
- The pharmacy had the current orders and had sent the medication supply in accordance with the MAR list.
- She did not have any verified orders from the physician or the pharmacy to disregard those medications not on the current MAR.
- Each medication aide supervisor had a list of resident's medication orders and duties to complete such as verifying and clarifying FL-2 orders.
- She was not sure if the resident's FL-2 medications not being administered had been verified on admission because the medication aide supervisor responsible for Resident #3's clarification/verification of the admission orders, no longer worked at the facility.
- The RCM did not know where the paper work was for the resident's medication verification.
- She would look for the verification of the resident's medications.
- There was not a system in place to ensure, by monitoring, the medication clarification and verifications system in place.

No verification, of the current FL-2 medication orders not being administered, was provided by

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D 344	Continued From page 20 the end of the survey.	D 344		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 residents (#6, #7) observed during the medication passes including errors with insulin and a vitamin supplement and 1 of 5 residents (#4) sampled who missed 8 doses of pain medication due to the medication being unavailable. The findings are: 1. The medication error rate was 8% as evidenced by the observation of 2 errors out of 25 opportunities during the 8:00 a.m. and 11:00 a.m. / 12:00 noon medication passes on 05/12/17. A. Review of Resident #7's current FL-2 dated	{D 358}		

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{D 358}	Continued From page 21	{D 358}		

05/11/17 revealed:
-The resident's diagnoses included diabetes mellitus type 2 without complications, hypertension, depressive disorder, dyspnea, and respiratory abnormalities.
-There was an order for Humalog insulin 20 units 3 times a day with meals, if blood sugar before the meal is less than 90 then inject 10 units after that meal instead of 20 units before the meal. (Humalog is rapid-acting insulin. According to the manufacturer, Humalog should be administered within 15 minutes before a meal or immediately after a meal.)

Review of Resident #7's May 2017 medication administration record (MAR) revealed:
-There was an entry for Humalog insulin, inject 20 units 3 times a day with meals and if blood sugar before the meal is less than 90, inject 10 units after that meal instead of 20 units before the meal.
-Humalog was scheduled to be administered at 7:30 a.m., 12:00 noon, and 5:00 p.m.
-The resident's blood sugar ranged from 120 - 461 in May 2017.

Observation during the medication pass on 05/12/17 revealed:
-The MA checked Resident #7's blood sugar and it was 325 at 11:26 a.m.
-The MA administered 20 units of Humalog insulin to Resident #7 at 11:29 a.m.

Interview and observation of Resident #7 on 05/12/17 at 12:05 p.m. revealed:
-Resident #7 was sitting in the dining room but no lunch had been served.
-She usually got insulin about 30 - 45 minutes before meals.
-She denied any current symptoms of low blood

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{D 358}	Continued From page 22 sugar. Observation of the dining room on 05/12/17 revealed Resident #7 was served lunch at 12:20 p.m., 51 minutes after receiving Humalog, a rapid-acting insulin. Interview with the MA on 05/12/17 at 1:10 p.m. revealed: -The lunch meal was usually served on time at 12:00 noon. -She usually gave insulin 30 minutes before meals, including rapid-acting insulin. -Humalog was scheduled on the MAR at 12:00 noon so she had to administer it by 12:00 noon. -She had not noticed the order indicated to give the Humalog with meals. Interview with the Resident Care Manager (RCM) on 05/12/17 at 1:20 p.m. revealed: -The MAs had diabetes training and they should know when to administer the insulin. -The facility's policy was to administer insulin, especially rapid-acting insulin, 5 - 10 minutes prior to eating and not more than 15 minutes prior to eating. Attempt to contact Resident #7's primary care provider on 05/12/17 was unsuccessful. B. Review of Resident #6's current FL-2 dated 01/08/17 revealed the resident's diagnoses included major neuro-cognitive disorder (dementia), schizoaffective disorder, and hypertension. Review of a physician's order for Resident #6 dated 01/12/17 revealed there was an order for Multivitamin with Minerals take 1 tablet daily in the morning with breakfast.) (Multivitamin with	{D 358}		

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{D 358}	Continued From page 23 Minerals is a vitamin/mineral supplement.) Review of Resident #6's May 2017 medication administration record (MAR) revealed: -There was an entry for Multivitamin with Minerals take 1 tablet every morning with breakfast -The Multivitamin with Minerals was scheduled to be administered at 8:00 a.m. Interview with the medication aide on 04/19/17 at 8:30 a.m. revealed breakfast was normally served around 8:00 a.m. Observation of the 8:00 a.m. medication pass on 5/12/17 revealed: -Multivitamin with Minerals was administered to Resident #6 at 8:54 a.m. -The resident was in bed in his room when his medications were administered. Interview with Resident #6 on 05/12/17 at 8:55 a.m. revealed: -The resident had not eaten any breakfast. -The resident did not usually eat breakfast. Interview with Resident #6 on 05/12/17 at 9:50 a.m. revealed he denied having any stomach irritation from taking the medication on an empty stomach. Interview with the medication aide on 05/12/17 at 10:09 a.m. revealed: -She had not noticed the instructions for the Multivitamin with Minerals was to administer with breakfast. -Resident #6 never ate breakfast. -If she had noticed the order, she would have contacted the physician to get the order changed since the resident never ate breakfast. -She would contact the physician today	{D 358}		

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{D 358}	Continued From page 24 (05/12/17). Interview with the Resident Care Manager (RCM) on 05/12/17 at 1:20 p.m. revealed: -When a medication was ordered with meals, it should be given when the resident started eating the meal. -If a resident skipped a meal routinely, the physician should be contacted to change the order. An attempt to contact Resident #6's primary care provider on 05/12/17 was unsuccessful. 2. Review of Resident #4's current FL-2 dated 11/03/16 revealed her diagnoses included generalized muscle weakness, cerebral infarct, toxic encephalopathy, sepsis, hypercalcemia, anemia, paroxysmal atrial fibrillation, urinary tract infection, and difficulty walking. Review of a physician's order dated 03/23/17 for Resident #4 revealed there was an order for Percocet 7.5mg/325mg take 1 tablet every 6 hours for pain, hold for sedation / absence of pain. (Percocet is a narcotic pain reliever.) Interview with Resident #4 on 05/11/17 at 11:24 a.m. revealed: -The facility ran out of her medications. -They ran out of her pain medication a couple of weeks ago. -She could not recall the exact dates but she was out of the medication from a Saturday until Tuesday. -She had broken both of her arms a couple of years ago and she took pain medication for chronic pain in her arms and shoulder. -She did not know why the facility ran out of the pain medication.	{D 358}		

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{D 358}	Continued From page 25 Review of Resident #4's April and May 2017 medication administration record (MAR) revealed: -There was an entry on both MARs for Percocet 7.5mg/325mg take 1 tablet every 6 hours for pain, hold for sedation. -Percocet was scheduled to be administered at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m. -Percocet was not administered from 6:00 p.m. on 04/29/17 through 12:00 p.m. on 05/01/17 (8 doses) due to "medication not in facility". Review of Resident #4's care notes revealed: -Staff contacted the resident's PCP on 04/29/17 and 04/30/17 for a new prescription for Percocet. -They received a prescription on 05/01/17. -There was no documentation the physician was contacted to get a new prescription for Percocet prior to 04/29/17. Review of pharmacy dispensing records for Resident #4 revealed: -There were 120 tablets (30 day supply) of Percocet 7.5/325mg dispensed on 03/30/17. -There were 120 tablets (30 day supply) of Percocet 7.5/325mg dispensed on 05/01/17. Interview with Resident #4 on 05/12/17 at 4:39 p.m. revealed: -When her pain medication was unavailable, her pain level would sometimes get to "8" on a scale of 0 (no pain) to 10 (worst pain.) -She did not know why her pain medication was unavailable recently. Interview with a medication aide on 05/12/17 at 5:43 p.m. revealed: -She was not sure why Resident #4 ran out of the Percocet. -The MAs were supposed to contact the	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077010	A. BUILDING: _____ B. WING _____	R 05/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{D 358}	Continued From page 26 physician to get a new hard script about a week prior to the medication running out. Interview with the Resident Care Manager (RCM) on 05/12/17 at 4:45 p.m. revealed: -She was not aware Resident #4 had missed doses of her pain medication. -The MA on duty was responsible for contacting the primary care provider (PCP) to get a hard copy prescription for narcotics when the medication got down to the blue strip on the bubble card, which was usually a one week supply of medication. -The MA could either call the PCP or fax them to get the hard copy prescription. -If a medication was unavailable, the MAs were supposed to notify the RCM.	{D 358}		
{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, record reviews, and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to health care. The findings are:	{D912}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D912}	Continued From page 27 Based on observations, interviews, and record reviews, the facility failed to assure health care needs were met for 2 of 5 sampled residents (#1, #3) as related to failure to contact the primary care provider (PCP) for a resident (#3) with multiple refusals of insulin administration and failure to notify the PCP of high blood sugars; and failure to contact the PCP for a resident (#1) with refusals of ten medications scheduled for 8:00 a.m. for 10 out of 11 days in May 2017. [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type B Violation).]	{D912}		