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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 03/05/19 to 03/07/19.	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 physician notification for 1 of 5 sampled residents (Resident #4) related to notifying the provider about weight gain and for 1 of 10 residents observed on the medication pass (Resident #13) related to making sure the resident attended a scheduled follow up appointment with labs to monitor for side effects and efficacy of treatment for a communicable viral infection. The findings are: 1. Review of Resident #4's current FL2 dated 02/10/19 revealed diagnoses included pneumonia, congestive heart failure (CHF), morbid obesity, and chronic kidney disease. Review of Resident #4's physician orders	D 273		

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revealed a physician order dated 02/12/19 to measure Resident #4's weight every Monday and Thursday and notify the provider of a weight gain greater than 3 pounds.

Review of Resident #4's February 2019 Medication Administration Record (MAR) revealed:
-There was a hand written entry to "check weights on Monday and Thursday, Call MD for 3 pound weight gain" scheduled to be measured at 9:00am on Monday and Thursday only.
-Resident #4's weight was documented as 264.5lbs on 02/14/19, 264lbs on 02/18/19, 268lbs on 02/21/19, 272lbs on 02/26/19, and 273lbs on 02/28/19.

Review of Resident #4's March 2019 MAR revealed:
-There was a hand written entry to "check weights on Monday and Thursday, Call MD for 3 pound weight gain" scheduled to be measured at 9:00am on Monday and Thursday only.
-Resident #4's weight was documented as 268.5lbs on 03/04/19.

Review of Resident #4's record revealed no documentation the primary care provider was contacted regarding the resident's increased weight during February 2019.

Interview with a medication aide (MA) on 03/06/19 on 12:30pm revealed:
-She did not know Resident #4 had a physician's order to contact the provider if the resident gained 3 pounds.
-She did not know it was on the MAR to contact Resident #4's provider regarding weight gain.

Interview with a MA on 03/06/19 at 7:56am

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revealed:
-The MAs were responsible for monitoring vital signs for the residents.
-The MAs were responsible for weighing Resident #4 based on his physician's order and contacting his provider if needed.
-The MA that measured the weight was responsible for contacting the provider if needed based on physician's order.
-She did not know why the provider was not notified of Resident #4's weight gain.

Interview with the Resident Care Coordinator (RCC) on 03/05/19 at 3:08pm revealed:
-She did not know Resident #4 had gained 9 pounds during the 2 weeks following his admission to the facility.
-She usually did not work as a MA but recently had been passing medications due to staffing shortages.
-The MA's were responsible for weighing the residents and notifying their providers if needed.
-She had weighed Resident #4 on 02/25/19.
-She did not know why Resident #4's provider was not contacted regarding his weight gain.
-The facility had a 24 hour report the MA's filled out daily to document things that needed to be followed up on for each resident.
-She was responsible for reviewing the 24 hour reports daily to make sure all tasks were completed.
-She was responsible for auditing MAR with new medication orders.
-She never saw a report containing information about Resident #4's weight.

Telephone interview with Resident #4's home health nurse on 03/05/19 at 4:03pm revealed:
-She had noticed Resident #4 had gained 9 pounds over two weeks on her visit to the facility

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on 02/26/19.
-She contacted Resident #4's provider to let them know of the weight gain on 02/26/19.
-She told the Administrator about Resident #4's weight gain and that she had contacted his provider on 02/26/19.

Interview with a Physician Assistant from Resident #4's primary care provider's (PCP) office on 03/05/19 at 12:20pm revealed:
-She did not know Resident #4 had gained almost 10 pounds over a two week period from the time he was admitted to the facility.
-Resident #4's home health nurse had contacted the provider's office when she discovered the weight gain when she had come to the facility to evaluate the resident.
-She expected the facility to contact her if Resident #4 started to gain weight.
-Resident #4 was at an increased risk for a CHF exacerbation, hospitalization, and respiratory failure if his fluid status was not controlled.

Interview with the Administrator on 03/06/19 at 11:50am revealed:
-She did not know Resident #4 had gained weight and his PCP needed to be notified.
-The MAs who measured the weight were responsible for notifying the PCP.
-The RCC was responsible for auditing the MARs.

2. Review of Resident #13's current FL2 dated 06/22/18 revealed diagnoses included chronic hepatitis C, anxiety, insomnia, and heart failure.

Review of Resident #13's Hepatitis C Treatment Appointment Schedule dated 11/08/18 revealed:
-Resident #13 was scheduled for 8 weeks of hepatitis C treatment from 11/05/18 and ending

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approximately on 12/31/18.
-Resident #13's treatment consisted of taking Mavyret (used to treat hepatitis) take 1 tablet daily for 8 weeks.
-Resident #13 was scheduled for a follow up office visit 4 weeks after starting therapy on 12/04/18 at 9:20am.
-At the follow up visit, Resident #13 was scheduled for labs to be drawn, including a complete blood count, liver function tests, and a hepatitis C viral load.

Review of the facility appointment calendar on 03/07/19 revealed:
-Resident #13's appointment on 12/04/18 at 9:20am was not listed on the calendar as a scheduled appointment.
-Resident #13 had an appointment scheduled for 12/05/18 at 9:00am.

Interview with Resident #13 on 03/07/19 at 9:04am revealed:
-He did not remember refusing to go to any appointments.
-He enjoyed getting out of the facility and going to his scheduled appointments.
-He did not know when any of his appointments were scheduled.

Interview with the Transport Manager on 03/07/19 at 8:50am revealed:
-He did not know Resident #13 had an appointment on 12/04/18 at the Gastroenterologist's office.
-The appointment was not documented on the appointment calendar.
-He did not remember seeing the paperwork that an appointment was scheduled for Resident #13 on 12/04/18.
-He was responsible for scheduling resident

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appointments for provider visits and for procedures.
-He was responsible for transporting all residents to their appointments.
-He was never late getting a resident to an appointment.
-He was responsible for rescheduling appointments if needed.
-He did not remember rescheduling any appointments for Resident #13.
-Resident #13 did not refuse to go to appointments.
-He did know Resident #13 was supposed to have a follow up with the Gastroenterologist in March, 2019.

Interview with the Resident Care Coordinator (RCC) on 03/07/19 at 9:12am revealed:
-She was responsible for giving the Transport Manager documentation if an appointment was scheduled for a resident or if an appointment needed to be scheduled.
-She did not know why the Transport Manager did not know about Resident #13's appointment on 12/04/19.
-She did not know if the Transport Manager had received Resident #13's treatment schedule documenting follow up appointments.
-She was not responsible for making sure the residents made it to their appointments.

Telephone interview with a nurse from Resident #13's Gastroenterologist's office on 03/06/19 at 1:10pm revealed:
-The Gastroenterologist was responsible for treating Resident #13's hepatitis C.
-Resident #4 was a "no show" for a scheduled appointment on 12/04/18.
-An appointment was rescheduled for 12/21/18 and the facility had called and canceled the

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appointment because Resident #13 was in the hospital.
-An appointment was rescheduled for 01/24/19 and the facility had called and canceled the appointment but a reason was not documented in the appointment software.
-Resident #13 did not currently have any appointments scheduled with the Gastroenterologist.
-The last appointment Resident #13 had with the Gastroenterologist was on 09/18/18 and had missed or the facility had canceled three appointments.
-It was very important for Resident #13 to make it to all follow up appointments after starting hepatitis C treatment.
-Labs should be drawn at the 4 week follow up after starting treatment to make sure the resident did not experience any side effects.
-The treatment Resident #13 was receiving worked on the liver so it was important for liver function tests to be drawn to monitor the liver.
-Resident #4 may experience side effects that included liver function changes, tiredness, rash, weakness, and headaches.

Review of Resident #13's Verification of Receipt of Medicaid Covered Services form dated 12/05/18 revealed Resident #13 was at the Gastroenterologist office.

Interview with the Operations Manager at Resident #13's Gastroenterologist's office on 03/07/19 at 11:10am revealed:
-Resident #13 was evaluated in the office on 09/19/18 as a new patient.
-The front desk receptionist would stamp the Verification of Receipt of Medicaid Covered Services form before she checked the schedule to make sure the resident had a scheduled

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D 273	Continued From page 7 appointment. -Resident #13 may have been in the office building on 12/05/18 but he was not evaluated by a provider because he did not have an appointment scheduled. Interview with the Administrator on 03/07/19 at 9:20am revealed: -She did not know Resident #13 had missed a scheduled appointment. -The Transport Manager was responsible for scheduling resident appointments and for transporting residents to appointments. -The MAs and RCC were responsible for making sure all documentation regarding residents that needed appointments scheduled was given to the Transport Manager. -The Transport Manager was responsible for keeping up with all the documentation used to schedule appointments. _____ The facility failed to notify the primary care physician for 1 of 5 sampled residents (#4) related to a 9 pound weight gain that increased the risk for a CHF exacerbation, hospitalization, and respiratory failure and the facility failed to ensure 1 of 10 residents observed during a medication pass (#13) attended a follow up appointment to monitor hepatitis C treatment that resulted in not having labs drawn to monitor for side effects and efficacy of treatment. Therefore it was detrimental to the health and well-being of residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/07/19 for this violation.	D 273		

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D 273	Continued From page 8 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 21, 2019.	D 273		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure a therapeutic diet list was maintained for the guidance of dietary staff for 6 of 8 residents sampled (#1, #3, #4, #5, #7, #10) who had physician's orders for a therapeutic diet. The findings are: Observation of the diet order list on 03/05/19 at 10:24am revealed it was posted in the kitchen on the door to the dining room. Review of the diet order list dated posted in the kitchen revealed there was a handwritten date of 03/02/19 over an area of white out in the upper right hand corner. Review of a second diet order sheet in the kitchen revealed: -It was not dated.	D 309		

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-It was handwritten on a piece of crumpled notebook paper.
-It was located under other papers on a kitchen table.

1. Review of Resident #1's current FL2 dated 10/30/18 revealed:
-Diagnoses included anxiety disorder, bipolar disorder, and mild depression.
-An order for a regular diet.

Review of a signed physician's order dated 02/08/19 revealed an order to change diet consistency to mechanical soft.

Review of the diet order sheet dated 03/02/19 posted in the kitchen revealed Resident #1 was ordered a regular diet.

Review of the second diet order sheet in the kitchen revealed Resident #1 was listed as chopped/mechanical soft diet.

Observation of the noon meal on 03/05/19 at 12:10pm revealed Resident #1 did not eat and was not served.

Interview with Resident #1 on 03/05/19 at 12:45pm revealed Resident #1's meals were of a mechanical soft type.

Refer to the interview with the Dietary Manager on 03/05/19 at 3:10pm.

Refer to the interview with the Executive Director on 03/05/19 at 3:22pm.

2. Review of Resident #3's current FL2 dated 05/15/18 revealed:
-Diagnoses included diabetes, sepsis, and

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D 309	Continued From page 10 osteomyelitis. -An order for a regular, no added salt, diet. Review of a signed physician's order dated 08/30/18 revealed a diet order for a regular, no added table salt, diet. Review of the diet order sheet dated 03/02/19 posted in the kitchen revealed Resident #1 was ordered a regular diet. Review of the second diet order sheet revealed Resident #3 was not listed on it. Interview with Resident #3 on 03/05/19 at 12:50pm revealed Resident #3 did not add salt to his meal. Refer to the interview with the Dietary Manager on 03/05/19 at 3:10pm. Refer to the interview with the Executive Director on 03/05/19 at 3:22pm. 3. Review of Resident #4's current FL2 dated 02/10/19 revealed diagnoses included pneumonia, congestive heart failure, and chronic kidney disease. Review of a signed physician's order dated 02/12/19 revealed a diet order for a regular, no added table salt, diet. Review of the diet order sheet dated 03/02/19 posted in the kitchen revealed Resident #4 was ordered a regular diet. Review of the second diet order sheet revealed Resident #4 was not listed on it.	D 309		

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D 309	Continued From page 11 Observation of the noon meal on 03/05/19 at 12:10pm revealed: -Resident #4 was served a grilled turkey and cheese sandwich, potato chips, vegetable soup, and pears. -There was a salt shaker on the table. -Resident #4 did not add salt to his meal. Refer to the interview with the Dietary Manager on 03/05/19 at 3:10pm. Refer to the interview with the Executive Director on 03/05/19 at 3:22pm. 4. Review of Resident #5's current FL2 dated 10/13/18 revealed diagnoses included diabetes, hypertension, and cerebral vascular accident. Review of a signed physician's order dated 01/28/19 revealed a diet order for a pureed diet. Review of the diet order sheet dated 03/02/19 posted in the kitchen revealed Resident #5 was ordered a regular diet. Review of the second diet order sheet in the kitchen revealed Resident #5 was on a pureed diet. Observation of the noon meal on 03/05/19 at 12:10pm revealed Resident #5 did not eat and was not served. Interview with the Dietary Manager on 03/05/19 at 3:10pm revealed she knew Resident #5 was on a pureed diet and always served it pureed. Refer to the interview with the Dietary Manager on 03/05/19 at 3:10pm	D 309		

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D 309	Continued From page 12 Refer to the interview with the Executive Director on 03/05/19 at 3:22pm. 5. Review of Resident #7's current FL2 dated 12/04/18 revealed: -Diagnoses included diabetes, hyperlipidemia, and hypertension. -An order for a regular no added salt diet. Review of a signed physician's order sheet dated 01/07/19 revealed a diet order for a regular no added table salt diet. Review of the diet order sheet dated 03/02/19 posted in the kitchen revealed Resident #7 was ordered a regular diet. Review of the second diet order sheet in the kitchen revealed Resident #7 was a diabetic with no specific diet order. Observation of the noon meal on 03/05/19 at 12:10pm revealed: -Resident #7 was served a grilled turkey and cheese sandwich, potato chips, vegetable soup, and pears. -There was a salt shaker on the table. -Resident #7 did not add salt to his meal. Refer to the interview with the Dietary Manager on 03/05/19 at 3:10pm. Refer to the interview with the Executive Director on 03/05/19 at 3:22pm. 6. Review of Resident #10's current FL2 dated 10/08/18 revealed: -There was no diagnosis listed. -An order for a no added salt diet.	D 309		

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D 309	Continued From page 13 Review of a signed physician's order sheet dated 10/08/18 revealed a diet order for a no added table salt, chopped meats, diet. Review of the diet order sheet dated 03/02/19 posted in the kitchen revealed Resident #10 was ordered a regular with chopped meats diet. Review of the second diet order sheet in the kitchen revealed Resident #10 was not listed. Observation of the noon meal on 03/05/19 at 12:10pm revealed: -Resident #10 was served two halves of a grilled turkey and cheese sandwich, potato chips, vegetable soup, and pears. -There was a salt shaker on the table. -Resident #10 did not add salt to his meal Refer to the interview with the Dietary Manager on 03/05/19 at 3:10pm. Refer to the interview with the Executive Director on 03/05/19 at 3:22pm. _____ Interview with the Dietary Manager on 03/05/19 at 3:10pm revealed: -Staff in the kitchen used the posted dietary orders list that was posted on the kitchen door. -The list was updated at least once per month by the Executive Director. -She would add to the list when there was new admission or dietary order changes. -She had a piece of notebook paper, a "cheat sheet", that she used for diet orders that she went by. -Salt was not added to the food when cooked. -Salt shakers were on the tables so residents could have a choice.	D 309		

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D 309	Continued From page 14 -She did not know why the diet order sheet was not correct. Interview with the Executive Director on 03/05/19 at 3:22pm revealed: -She had updated the diet order list in the kitchen on 03/04/19. -She did not know why the list was not accurate. -The list had been updated when there was a new admission or diet order changes. -A medication aide or the Resident Care Coordinator would bring her the order changes to make the updates.	D 309		
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:	D 344		

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D 344	Continued From page 15 TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure contact with the prescribing physician for clarification of orders for 1 of 5 sampled residents (#4) related to medication orders for Demadex and 1 of 10 residents (#12) observed on the medication pass related to medication orders for the administration of Ativan. The findings are: 1. Review of Resident #4's current FL2 dated 02/10/19 revealed: -Diagnoses included pneumonia, congestive heart failure (CHF), morbid obesity, and chronic kidney disease. -There was a physician's order for Demadex 20mg take three tablets twice daily (used to treat fluid retention). Review of Resident #4's Resident Register revealed an admission date of 02/11/19 from a skilled nursing facility following an extended hospital admission for CHF, fluid retention, and chronic kidney disease management. Review of Resident #4's physician's order dated 02/11/19 revealed there was a physician's order for Demadex 20mg take one tablet three times daily. Review of Resident #4's February 2019 Medication Administration Record (MAR) revealed: -There was a hand written entry for Demadex 20mg 3 tablets twice daily scheduled to be administered daily at 9:00am and 2:00pm. -Demadex 20mg was documented as	D 344		

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administered twice daily at 9:00am and 2:00pm from 02/12/19 to 02/28/19.
-The hand written entry for Demadex was originally recorded with directions to take one tablet twice daily but the one had been written over with a three.

Review of Resident #4's March 2019 MAR revealed:
-There was a computer generated entry for Demadex 20mg take 3 tablets twice daily scheduled to be administered at 8:00am and 8:00pm.
-The administration times were crossed out and changed to 9:00am and 2:00pm.
-The Demadex was documented as administered twice daily from 03/01/19 to 03/05/19.

Review of Resident #4's record revealed on 03/06/19 revealed there was no documentation Resident #4's provider had been contacted to clarify the conflicting orders for Demadex dated 02/10/19 for 20mg take three tablets twice daily and the order dated 02/11/19 for 20mg take one tablet three times daily.

Observation of medications on hand on 03/05/19 at 3:08pm revealed there were a total of 135 tablets of Demadex 20mg available to be administered to Resident #4.

Telephone interview with a pharmacist from Resident #4's facility contracted pharmacy on 03/05/19 at 3:54pm revealed:
-A quantity of 97 tablets with a 32 day supply of Demadex 20mg was dispensed to Resident #4 on 02/11/19 with the directions take one tablet three times daily.
-The medication order was from Resident #4's provider's office visit summary dated 02/11/19.

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D 344	Continued From page 17 -The pharmacy tried to process the Demadex order from Resident #4's FL2 dated 02/10/19 on 02/15/19 with the directions Demadex 20mg take three tablets twice daily but it was rejected from the insurance because it was too early to fill. -A quantity of 165 tablets with a 28 day supply of Demadex 20mg was dispensed to Resident #4 on 02/26/19 with the directions take three tablets twice daily. -The facility staff should have returned the Demadex dispensed on 02/11/19 to the pharmacy to be repackaged when the directions for the medication had changed. Interview with Resident #4 on 03/05/19 at 4:21pm revealed: -He did not know what medications he was currently receiving because he had a lot of medications. -He had noticed his legs had started to swell. Interview with a medication aide on 03/06/19 on 12:30pm revealed: -She administered 1 tablet of Demadex to Resident #4 on the morning of 02/19/19, 02/20/19, and 02/21/19. -She was responsible for comparing the medication card to the MAR before administering medications. -The medication card from the pharmacy stated Demadex one tablet three times daily and the February MAR had matched the medication card. -Someone had changed Resident #4's February MAR to Demadex 20mg three tablets twice daily when she returned to the medication cart on 02/26/19. -She did not know Resident #4 had two different orders for Demadex. Interview with the Resident Care Coordinator	D 344		

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D 344	Continued From page 18 (RCC) on 03/06/19 at 8:40am revealed: -She had always administered 3 tablets of Demadex to Resident #4. -She did not know Resident #4 had two orders for Demadex dated one day apart. -She or the MAs were responsible for clarifying medication orders. Telephone interview with Resident 4's home health nurse on 03/05/19 at 4:03pm revealed: -She had noticed Resident #4 had gained 9 pounds over a two week period on her visit to the facility on 02/26/19. -She counted Resident #4's Demadex in the medication cart and determined the resident was not receiving the correct dose of medication based on medication available for administration. -She told the MA and the Administrator that Resident #4 should be receiving Demadex 20mg take 3 tablets twice daily. Interview with a physician assistant from Resident #4's primary care provider's office on 03/05/19 revealed: -Resident #4 should be receiving Demadex 20mg three tablets twice daily. -Resident #4's home health nurse had contacted the provider's office on 02/26/19 when she discovered the resident was not receiving the correct dose of Demadex. -She did not know the provider's office summary dated 02/11/19 stated a different order for the Demadex. -The facility should have called to clarify the medication order for Demadex. -It was important for Resident #4 to receive the correct dose of Demadex to maintain his fluid balance. -Resident #4 was at an increased risk for a CHF exacerbation, hospitalization and respiratory	D 344		

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failure if his fluid level was not controlled.

Interview with the Executive Director on 03/06/19 at 11:50am revealed:
-She did not know Resident #4 was not receiving the correct dose of Demadex.
-She remembered talking to the home health nurse but not about Resident #4's medication.

Refer to the interview with the Resident Care Coordinator (RCC) on 03/06/19 at 8:40am.

Refer to the interview with the Executive Director on 03/06/19 at 11:50am.

2. Review of Resident #12's current FL2 dated 02/28/19 revealed:
-Diagnoses included neuropathy, congestive heart failure, diabetes, and hypertension.
-Under medications, it stated to "see attached med list"
-Attached medication list was printed on 01/24/19.
-There was an order for Lexapro 10mg take 1 tablet daily (used to treat depression).
-There was an order for Ativan 0.5mg take 1 tablet 3 times daily (used to treat anxiety)

Review of Resident #12's Resident Register revealed an admission date of 03/01/19.

Review of Resident #12's primary care provider visit summary documentation revealed:
-There was a medication list from Resident #12's primary care provider dated 03/01/19.
-There was a physician's order for Ativan 1mg take 1 tablet 3 times daily.

Review of Resident #12's March Medication Administration Record (MAR) revealed:

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-There was a hand written entry for Ativan 0.5mg take half tablet 3 times daily scheduled to be administered at 8:00am, 2:00pm and 8:00pm.
-Ativan was documented as administered from 03/04/19 to 03/06/19.

Observation of medications on hand on 03/06/19 at 8:19am revealed:
-There was a bottle of Ativan 1mg available to be administered to Resident #12.
-The 82 tablets of Ativan 1mg was dispensed to Resident #12 on 02/14/19 from a pharmacy not contracted with the facility.
-There was an orange sticker covering the directions on the prescription bottle stating "Directions Changed, Refer to Chart."
-There was directions written in black ink on the bottle lid to administer a half tablet at 8:00am, 2:00pm, and 8:00pm.

Telephone interview with a pharmacy technician from Resident #12's pharmacy on 03/06/19 at 10:11am revealed 82 tablets of Ativan 1mg were dispensed to Resident #12 on 02/14/19.

Review of Resident #12's record revealed no documentation that Resident #12's provider had been contacted to clarify the conflicting orders for Ativan dated 02/28/19 for 0.5mg take 1 tablet 3 times daily and an order dated 03/01/19 for Ativan 1mg take 1 tablet 3 times daily.

Interview with Resident #12 on 03/07/19 at 9:02am revealed:
-The facility has only been giving her a half table of Ativan while she was taking a whole tablet before admission.
-She did not know if her Ativan dose was changed when she moved to the facility.
-She believed she was receiving all her

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medication because she was taking a lot of medications.

Interview with the Resident Care Coordinator (RCC) on 03/06/19 at 9:55am revealed:
-She was not working when Resident #12 was admitted.
-The MA had prepared Resident #12's initial MAR on admission.
-She administered Ativan to Resident #12 based on the MAR and not the pharmacy label.
-She had administered a half of a tablet of Ativan to Resident #12 on the morning of 03/06/19.
-Resident #12 had brought medication to the facility when she was admitted.
-She did not know there were multiple orders for Ativan in Resident #12's record.

Telephone interview with a nurse from Resident #12's primary care provider's office on 03/07/19 at 3:00pm revealed:
-Resident #12 should be taking Ativan 1mg take 1 tablet three times daily.
-Resident #12 Ativan dose was titrated and discontinued on 12/26/18.
-Resident #12 had increased anxiety, restlessness, and agitation when the medication was discontinued.
-Resident #12's primary care provider restarted the Ativan on 01/07/19 and had increased the dose to 1mg take 1 tablet three times daily on 02/14/19.
-The facility was responsible for making sure each resident was administered medication as prescribed by their provider.
-The facility should have clarified the medication order.

Telephone interview with a pharmacist from Resident #12's pharmacy on 03/07/19 at 3:27pm

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D 344	Continued From page 22 revealed: -Resident #12 could be at risk for increased anxiety or panic attacks and possible hospitalization if given the incorrect dose of Ativan. -If medication was titrated too fast or stopped suddenly then Resident #12 was at an increased risk for seizures. Refer to the interview with the Resident Care Coordinator (RCC) on 03/06/19 at 8:40am. Refer to the interview with the Executive Director on 03/06/19 at 11:50am. _____ Interview with the Resident Care Coordinator (RCC) on 03/06/19 at 8:40am revealed: -Any medication orders that were not clear should be clarified. -She was responsible for preparing the initial MAR when a resident was admitted to the facility. -The MAs were helping prepare MARs recently because she was needed on the medication cart. -The MAs should follow the MAR when administering medications. -Initial MARs were prepared according to the admitting FL2. -She did not have a system to audit MARs. Interview with the Executive Director on 03/06/19 at 11:50am revealed: -The RCC was responsible for following the FL2 when preparing an MAR on admission for a resident. -The FL2 should be faxed to the pharmacy for the pharmacy to send medications for the resident. -Any medication order that was unclear should be clarified. -The RCC was responsible for clarifying	D 344		

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D 344	Continued From page 23 medication orders. -The RCC was responsible for auditing MARs compared to new medication orders monthly when the MARs were updated. -The RCC and MAs were responsible for auditing the medication cart compared to MAR weekly. -The RCC was responsible for ensuring all medication orders were correct on the MAR. _____ The failure of the facility to clarify medication orders on admission for 1 of 5 sampled residents (#4) for Demadex resulted in resident receiving the wrong dose of medication and gaining 9 pounds over a two week period increasing the risk for a CHF exacerbation, hospitalization and respiratory failure and for 1 of 10 residents observed on a medication pass (#12) for Ativan resulted in the resident receiving half of the dose of Ativan prescribed by the physician putting her at risk for increased anxiety, panic attacks, and possible hospitalization was detrimental to the health and well-being of residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/06/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 21, 2019.	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	D 358		

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D 358	Continued From page 24 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 B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure insulin was administered as ordered by a licensed prescribing practitioner for 1 of 4 sampled residents (Resident #7) with orders for insulin. The findings are: Review of Resident #7's current FL2 dated 12/04/18 revealed: -Diagnoses included diabetes, hyperlipidemia, and hypertension. -There was an order for Novolog Mix 70-30 Flexpen (A mix of 70% insulin aspart protamine and 30% insulin aspart used to regulate blood sugar-peak action 2 hours) 48 units twice daily. -There was an order for Lantus Solostar (used to regulate blood sugar for 18 to 26 hours) 35 units twice daily.	D 358		

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D 358	Continued From page 25 Review of Resident #7's signed physician order sheet dated 01/08/19 revealed: -There was an order for Novolog Mix 70-30 Flexpen 48 units twice daily. -There was an order for Lantus Solostar 35 units twice daily. -There was an order for fingerstick blood sugar (FSBS) monitoring four times daily at 7:30am, 11:30am, 4:30pm and 8:30pm. Review of Resident #7's physician order dated 01/23/19 revealed FSBS monitoring twice daily in the morning and at hour of sleep. Interview with Resident #7 on 03/05/19 at 9:15am revealed: -The resident was a diabetic and was on two different types of insulin to regulate his blood sugar. -His insulin's were administered via insulin pens twice a day. -The facility had "run out" of the insulin pens "at times." -The resident was not sure which insulin had "run out." -The resident was not sure know how long the insulin had been out. Observation of Resident #7's insulin on 03/06/19 at 10:00am revealed there was no Novolog Mix 70-30 Flexpens available on the medication cart nor in the facility medication refrigerator for administration. Interview with the medication aide (MA) on 03/06/19 at 10:15am who administered medications to Resident #7 on the morning of 03/06/19 revealed: -Resident #7 was out of the Novolog Mix 70-30 Flexpen.	D 358		

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D 358	Continued From page 26 -"I just used the last this morning." -Resident #7's next scheduled dose of Novolog Mix 70-30 would be at 4:30pm. -The refill request for the Novolog Mix 70-30 had been submitted to the pharmacy on 03/05/19, but the pharmacy had been unable to fill it because they needed a new physician's order. -She had obtained the new physician's order "this morning." -"Usually" the insulin was ordered for the resident "before he runs out." -The pharmacy delivered insulin the same day they ordered it. -If a medication was ordered before 2pm, it was delivered by the pharmacy at 4pm. -There was a second daily pharmacy delivery at 11pm. Review of a fax transmission verification report dated 03/05/19 at 7:59pm revealed: -The fax was sent to the facility's contracted pharmacy. -It was a refill request for Resident #7's Novolog 70/30 Mix insulin. -The refill request did not document Resident #7 was completely out of the Novolog Mix 70-30 Flexpen to the pharmacy. Interview with the contracted facility pharmacy on 03/06/19 at 10:20am revealed: -Resident #7's Novolog 70-30 Flexpen had been filled at 9:30am on 03/06/19 and would arrive on delivery in time for his 4:30pm scheduled dose. -The pharmacy had last dispensed Resident #7's Novolog 70-30 Flexpens on 02/12/19 which provided a 16 day supply of the medication. Interview with Resident #7 on 03/06/19 at 11:22am revealed: -He received insulin twice a day at 7am and 4pm.	D 358		

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-"Every now and again the pens run dry."
-He had received two insulin pen injections that morning.
-One injection was from a gray colored pen (Lantus) and the second injection was from a dark blue colored pen (Novolog Mix 70-30).
-"They ran out" of his insulin "yesterday, but they gave me somebody else's medication."
-"We are waiting on the pharmacy to send a new supply."

Interview with the same MA on 03/06/19 at 11:40am revealed:
-Resident #7's Novolog Mix 70-30 insulin refill request was faxed to the pharmacy yesterday.
-The refill request was faxed again "today and called" to the pharmacy.
-"We have one other person who has Novolog 70-30 insulin."
-"I borrowed 3 units out of a vial" from another resident's insulin.
-Resident #7 "gets 48 units."
-"I used 45 units out of his pen and 3 units from a vial from [Resident #11's name]."
-This was the first time she had ever had to borrow a medication.

Review of the facility's medication borrowing policy revealed:
-Staff were only to borrow medications in "extreme emergency situations."
-Borrowing was to be documented and borrowed medications replaced.

Observation of the insulin vial from which the MA borrowed on 03/06/19 at 11:49am revealed:
-The vial was labeled with Resident #11's name.
-The vial was labeled Novolin 70-30 (A mix of 70% insulin isophane and 30% regular insulin used to regulate blood sugar peak action 4 hours)

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inject 35 units every morning.
-The insulin was dispensed on 02/22/19.
-Approximately half of the insulin remained in the vial.

Interview with Resident #7 on 03/06/19 at 3:00pm revealed:
-He had received his insulin on the morning of 03/06/19 from staff from two insulin pens.
-He had received his insulin on 03/05/19 at 4:30pm from staff from two insulin pens.
-His blood sugar "dropped last night."
-"I hate it when it gets down."

Review of Resident #7's March 2019 Medication Administration Record (MAR) revealed:
-There was an entry for Novolog 70-30 Mix Flexpen inject 48 units twice daily scheduled for 7:30am and 4:30pm.
-The Novolog 70-30 was documented 11 occurrences out of 11 opportunities from 03/01/19 to 03/06/19 at 7:30am.
-There was an entry for FSBS monitoring at breakfast and hour of sleep.
-On 03/05/19 at breakfast, the FSBS was 149.
-On 03/05/19 at hour of sleep, the FSBS was 153.
-On 03/06/19 at breakfast, the FSBS was 164.

Interview on 03/06/19 at 3:20pm with the MA who had administered Resident #7's scheduled insulin on 03/05/19 revealed:
-There had been enough Novolog Mix 70-30 in the Flexpen to administer the entire 48 units at the 7:30am administration on 03/05/19.
-There had been only 20 units left in the Novolog Mix 70-30 Flexpen for the dose due on 03/05/19 at 4:30pm.
-She administered the remaining 20 units from the Novolog 70-30 Flexpen.

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-She had also administered 28 units of insulin she had "borrowed" from Resident #11's vial of Novolin 70-30 insulin.
-Resident #7 had received 3 injections of insulin on 03/05/19 at 4:30 including one injection of Lantus via pen, one 20 unit injection of Novolog Mix 70-30 via Flexpen, and 28 units of Novolin 70-30 via syringe.
-She had worked until 7:30pm on 03/05/19 and Resident #7 had not reported any problems with his blood sugar to staff.

Interview with the medication aide (MA) on 03/06/19 at 3:30pm who had administered medications to Resident #7 on the morning of 03/06/19 revealed:
-She had not been truthful in the earlier interview at 10:15am on 03/06/19.
-She had administered 48 units of Novolin 70-30 insulin via syringe to Resident #7 that she had borrowed from Resident #11.
-She had reported borrowing the insulin from Resident #11 to give to Resident #7 to the Resident Care Coordinator on the morning of 03/06/19.
-This was the first time she had ever borrowed a medication to administer to a resident.

Telephone interview with the contracted facility pharmacy on 03/07/19 at 9:06am revealed:
-They had dispensed Novolog 70-30 Mix Flexpens on the following dates: 01/10/19, 01/28/19, 02/12/19, and 03/06/19.
-Each dispense was for 15ml which was 5 Flexpens with 3ml or 300 units in each pen.
-Each 15ml was enough insulin for a 16 day supply.
-The facility had faxed a request to refill Resident #7's Novolog 70-30 on 03/05/19 at 7:58pm.
-The pharmacy had not received any other

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D 358	Continued From page 30 requests to refill since 02/12/19. Interview with the Licensed Health Professional Support Nurse on 03/07/19 at 9:55am revealed: -Insulin Flexpen were delivered from the pharmacy in packs of 5. -The MAs had been trained to pull the medication sticker off the plastic bag which held Resident #7's insulin Flexpen's and fax it to the pharmacy to request a refill when they began to use the resident's last available Flexpen. Interview with the Executive Director on 03/07/19 at 10:27am revealed: -The facility policy allowed for the borrowing of medications only for an "emergency situation" just once. -The borrowed medication was to be documented and replaced. -The physician was to be notified when borrowing occurred. -"We don't borrow very often." -The contracted facility pharmacy had made a delivery to the facility at 1:00am on 03/06/19 and the Novolog Mix 70-30 Flexpens could have been delivered then. -Communication between facility staff and the contracted pharmacy was "key." Telephone interview with Resident #7's Nurse Practitioner on 03/08/19 at 11:30am revealed: -There was a difference between the onset and peak action times of Novolog 70-30 Mix insulin and Novolin 70-30 Mix insulin. -There was a 2 hour difference between peak action times of the two insulins. -She did not think the resident having received 2 doses of Novolin 70-30 Mix insulin had "hurt" the resident. -However, she did not want staff to borrow insulin	D 358		

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D 358	Continued From page 31 between residents. -"I will educate them next week when I'm there to not borrow insulin." _____ Based on observations, interviews, and record reviews, the facility failed to assure insulin was administered as ordered by a licensed prescribing practitioner for 1 of 4 sampled residents (Resident #7) with orders for insulin. This failure of not receiving insulin as ordered could result in hypoglycemic episodes which was detrimental to the health and safety of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/08/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 21, 2019.	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 regulations. This Rule is not met as evidenced by:	D912		

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D912	Continued From page 32 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, medication administration, and medication orders. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure physician notification for 1 of 5 sampled residents (Resident #4) related to notifying the provider about weight gain and for 1 of 10 residents observed on the medication pass (Resident #13) related to making sure the resident attended a scheduled follow up appointment with labs to monitor for side effects and efficacy of treatment for a communicable viral infection.[Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to assure contact with the prescribing physician for clarification of orders for 1 of 5 sampled residents (#4) related to medication orders for Demadex and 1 of 10 residents (#12) observed on the medication pass related to medication orders for the administration of Ativan.[Refer to Tag 344, 10A NCAC 13F .1002(a)(2) Medication Orders (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to assure insulin was administered as ordered by a licensed prescribing practitioner for 1 of 4 sampled residents (Resident #7) with orders for insulin.[Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		

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D932	Continued From page 33	D932		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV,	D932		

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D932	Continued From page 34 hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to implement an infection control policy consistent with the Centers for Disease Control and Prevention guidelines to ensure proper infection control procedures were followed for the storage of sharps containers resulting in containers being easily accessible to residents, turning over and spilling contents on medication carts, and facility staff being able to remove contents from the containers. Observation of medication carts on 03/05/19 at 12:58pm revealed: -The facility had four medication carts. -All the medication carts were stored in an unsecured, open common area outside of the resident living room and the hallway leading to the dining room. -There were approximately 15 residents either walking through the hallway or in the living room. -There were sharps containers sitting on the top of 3 of 4 medications carts. -The sharps containers were unsecured with lids open on each of the 3 medication carts.	D932		

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D932	Continued From page 35 Review of the CDC (Center for Disease Control and Prevention) guidelines for infection controlled revealed: -Sharp containers should be stored upright and easy to open while preventing the contents from spilling. -Special situations may require innovative sharp disposal container placement and security approaches. -These special situations may include geriatric wards and mental health facilities with high patient and visitor traffic. -The sharp disposal containers in these situations should be mounted in a lockable fixture. -When sharp disposal containers are moved from one area to another, the container should be closed immediately to prevent spillage or protrusion of contents during handling, storage, or transport. -Injuries from improper sharp disposal can occur if the container is inappropriately placed. Review of the OSHA (Occupational Safety and Health Administration) guidelines for contaminated sharps container revealed: -During use, containers for contaminated sharps must be maintained upright throughout use. -The mechanism to restrain the sharps containers was one way to prevent spillage during use. -The placement of sharps containers and the measures used to maintain them in an upright position during use must be based on the site specific hazard assessment of the area of intended use. Observation of the medication cart during medication pass on 03/05/19 at 11:30am revealed:	D932		

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D932	Continued From page 36 -The Resident Care Coordinator (RCC) was pushing a medication cart down the hall to administer medications to a resident. -The RCC turned the medication cart around to push it up against the wall out of the middle of the hallway. -The sharps container turned over on top of the medication cart and two small tablets fell out of the sharps container on the top of the medication cart. -The RCC picked up the sharps container and set it back on top of the medication cart and put the tablets back into the container. Review of the facility's policy on Infection Control and Standard Precautions revealed: -Standard precautions should be used by all staff at all times when necessary. -Standard precautions were safeguards were used to keep individuals protected and healthy when they may come in contact with infectious fluids, blood or other bodily fluids. -Policy did not include how to properly store a sharps container. Interview with a medication aide (MA) on 03/05/19 at 11:51am revealed: -The sharps containers needed to be replaced earlier in the week because they were full. -They had to go to a backup pharmacy to purchase sharp containers because their order had not arrived from the "supply company." -They were only going to use the sharps containers sitting on top of the medication carts until the new containers arrived that could be secured onto the medication cart. Interview with the Corporate Director of Clinical Services on 03/06/19 at 1:55pm revealed she and the Administrator were able to open the lid to the	D932		

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D932	Continued From page 37 sharps container from one of the medication carts and turn it upside down and remove a contaminated insulin pen from the container. Interview with the RCC on 03/05/19 at 11:35am revealed: -The sharp containers that fit onto the medication cart were ordered several weeks ago. -The sharp containers on the medication carts were used for supplies used for finger stick blood sugar checks and insulin administration. -The sharps containers were also used for disposal of contaminated medications that needed to be destroyed. Review of a purchase order revealed: -The Administrator had created the purchase order on 02/12/19 for 4 sharps containers and had sent the order to corporate for approval. -The purchase order received a final approval on 02/13/19 and was sent to the supplier. Review of the receipt from the facility's backup pharmacy revealed 4 sharps containers were purchased on 03/04/19. Interview with the Administrator on 03/06/19 at 1:10pm revealed: -She, the RCC, the activities director, and the dietary manager were authorized to order supplies. -The sharps containers that can be locked onto the medication cart were on order. -The sharps containers that were on the medication carts needed to be replaced on 03/04/19 because they were full. -She was notified by that MAs that the order for the new sharps containers had not arrived. -She did not know the facility was out of sharps containers until she was notified by the MAs on	D932		

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D932	Continued From page 38 03/04/19. -The facility purchased sharps containers from a backup pharmacy to use on the medication carts until the order arrived for the containers that could be secured on the medication cart.	D932		