STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	12/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 an annual survey on 12/18/19 and 12/19/19 with an exit conference via telephone on 12/20/19.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure hot water temperatures were maintained between 100 and 116 degrees (°) Fahrenheit (F) as evidenced by hot water temperatures higher than 116°F for 2 of 6 water fixtures, including a sink and a shower. The findings are: Observation of a residents bathroom on 12/18/19 at 9:35am revealed the hot water temperature at the sink was 122°F and there was visible steam when the water was running. Interview with the resident who resided in Room #5 on 12/18/19 at 9:35am revealed he had never been burned by the hot water at the sink in his bathroom.	D 113		

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D 113	Continued From page 1 Observation of the shared bathroom on 12/18/19 at 10:20am revealed the hot water temperature at the shower was 120°F and there was visible steam when the water was running. Observations of re-check of water temperatures on 12/19/19 revealed: -At 9:15am, the hot water temperature at the sink in the residents bathroom was 119°F. -At 9:20am, the hot water temperature at the shower in the shared bathroom was 118°F. Interview with the Administrator on 12/20/19 at 3:00pm revealed: -She had not been aware of any hot water issues. -She did not have a water temperature log book because she did not know that she was supposed to check water temperatures and keep a record of them. -There were no reports of any residents receiving burns from the hot water temperatures. -A new hot water heater was installed at the facility around two months ago. -She did not know how to adjust the hot water temperature and would have to call a plumber.	D 113		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902	D 131		

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D 131	Continued From page 2 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled staff (Staff C) was tested for the tuberculosis (TB) disease with a two-step skin test in compliance with control measures adopted by the Commission for Public Health. The findings are: Review of Staff C's personnel record revealed: -She was hired 02/13/17 as a personal care aide (PCA) and as a medication aide (MA). -There was documentation of a negative TB skin test read on 02/17/17. -There was no documentation of a second TB skin test. Telephone interview with Staff C on 12/19/19 at 9:45am revealed: -She remembered having a TB test completed when she was hired. -She did not have a second TB skin test completed. Interview with the Administrator on 12/18/19 at 4:35pm revealed: -She did not know Staff C did not have a second TB test completed after she was hired. -She was responsible for making sure all new employees received their two step TB test upon hire.	D 131		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up	D 273		

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D 273	Continued From page 3 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 notify the physician for 1 of 3 sampled residents (Residents #2) related to notifying the physician regarding frequent low fingerstick blood sugar readings. The findings are: Review of Resident #2's current FL2 dated 01/07/19 revealed diagnoses included diabetes, hypertension, mental retardation, allergies, and hyperlipidemia. Review of Resident #2's physician's order dated 04/05/19 revealed: -There was a physician's order to notify the provider if Resident #2 had frequent low fingerstick blood sugar (FSBS) readings. -If the FSBS was <70 then the facility staff needed to administer 4 ounces of orange juice to Resident #2 and recheck the FSBS in 15 minutes and repeat this process until the FSBS was >80. Review of Resident #2's physician's order dated 10/07/19 revealed there was a physician's order to check FSBS four times daily before meals and	D 273		

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D 273	Continued From page 4 at bedtime. Observation of the medication pass on 12/18/19 at 11:45am revealed: -The medication aide (MA) checked Resident #2's FSBS in the medication room. -Resident #2 walked into the medication room and stood while the MA checked his FSBS. -Resident #2's FSBS was 51. -The MA gave Resident #2 4 ounces of orange juice and had him sit in the dining room for observation. Observation of Resident #2's FSBS rechecked by the MA on 12/18/19 at 12:34pm revealed his FSBS was 44 and the resident was given another 4 ounces of orange juice, and was served lunch. Interview with the MA on 12/18/19 at 3:10pm revealed: -She never called Resident #2's primary care provider regarding low FSBS. -Resident #2's FSBS was low sometimes when she worked. -The MAs were responsible for notifying the provider regarding high FSBS but she had never called about a low FSBS. -She usually told the Administrator if the provider needed to be called about a resident's FSBS and she "took care of it." Review of Resident #2's October, November, and December 2019 Medication Administration Record revealed no documentation related to the provider being contacted regarding a low or high FSBS reading. Review of Resident #2's October 2019 FSBS readings log revealed: -Resident #2's FSBS was checked three times	D 273		

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D 273	Continued From page 5	D 273		

daily from 10/01/19 through 10/23/19 and four times daily from 10/24/19 through 10/31/19.
-FSBS results were documented daily at 8:00am, 12:00pm, 5:00pm and 8:00pm.
-From 10/01/19 to 10/31/19 at 8:00am, Resident #2's FSBS was <70 for 10 out of 31 opportunities.
-FSBS was documented at 8:00am on 10/03/19 at 58, 10/07/19 at 61, 10/09/19 at 49, 10/11/19 at 68, 10/14/19 at 65, 10/15/19 at 49, 10/17/19 at 47, 10/18/19 at 53, 10/20/19 at 42, and 10/24/19 at 46.
-From 10/01/19 to 10/31/19 at 12:00pm, Resident #2's FSBS was <70 for 4 out of 31 opportunities.
-FSBS was documented at 12:00pm on 10/02/19 at 56, 10/09/19 at 66, 10/10/19 at 65, and 10/18/19 at 46.
-From 10/01/19 to 10/31/19, Resident #2's FSBS was <70 for 15 out of 31 opportunities.
-FSBS was documented at 5:00pm on 10/03/19 at 67, 10/04/19 at 55, 10/05/19 at 38, 10/09/19 at 47, 10/10/19 at 63, 10/11/19 at 52, 10/13/19 at 62, 10/15/19 at 60, 10/17/19 at 50, 10/18/19 at 62, 10/19/19 at 61, 10/21/19 at 58, 10/24/19 at 61, 10/25/19 at 35, and 10/26/19 at 51.

Review of Resident #2's November 2019 FSBS readings log revealed:
-Resident #2's FSBS was checked four times daily from 11/01/19 through 11/30/19.
-FSBS results were documented daily at 8:00am, 12:00pm, 5:00pm and 8:00pm.
-From 11/01/19 through 11/30/19, Resident #2's FSBS was documented as <70 for 3 out of 30 opportunities.
-FSBS was documented at 8:00am on 11/05/19 at 62, 11/15/19 at 50, and 11/25/19 at 66.
-From 11/01/19 through 11/30/19, Resident #2's FSBS was documented as <70 for 11 of out 30 opportunities.
-FSBS was documented at 5:00pm on 11/01/19

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D 273	Continued From page 6	D 273		

at 52, 11/02/19 at 58, 11/06/19 at 50, 11/08/19 at 42, 11/09/19 at 68, 11/10/19 at 58, 11/15/19 at 52, 11/20/19 at 54, 11/22/19 at 37, 11/23/19 at 37, and 11/29/19 at 43.
-From 11/01/19 through 11/30/19, Resident #2's FSBS was documented as <70 for 4 out of 30 opportunities.
-FSBS was documented at 8:00pm on 11/05/19 at 55, 11/10/19 at 44, 11/21/19 at 63, and 11/25/19 at 45.

Review of Resident #2's December 2019 FSBS readings log revealed:
-Resident #2's FSBS was checked four times daily from 12/01/19 through 12/18/19.
-FSBS results were documented daily at 8:00am, 12:00pm, 5:00pm and 8:00pm.
-From 12/01/19 through 12/18/19 at 8:00am, Resident #2's FSBS was documented as <70 for 6 out of 18 opportunities.
-FSBS was documented at 8:00am on 12/04/19 at 48, 12/09/19 at 63, 12/12/19 at 46, 12/13/19 at 44, 12/14/19 at 56, and 12/18/19 at 51.
-From 12/01/19 through 12/18/19 at 12:00pm, Resident #2's FSBS was documented as <70 for 2 out of 18 opportunities.
-FSBS was documented at 12:00pm on 12/12/19 at 68 and 12/18/19 at 51.
-From 12/01/19 through 12/17/19 at 5:00pm, Resident #2's FSBS was documented as <70 for 11 out of 17 opportunities.
-FSBS was documented at 5:00pm on 12/01/19 at 33, 12/02/19 at 66, 12/03/19 at 31, 12/04/19 at 48, 12/06/19 at 45, 12/09/19 at 45, 12/11/19 at 35, 12/12/19 at 56, 12/13/19 at 35, and 12/16/19 at 62.
-From 12/01/19 through 12/17/19 at 8:00pm, Resident #2's FSBS was documented as <70 for 1 out of 17 opportunities.
-FSBS was documented at 8:00pm on 12/14/19

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D 273	Continued From page 7 at 55. Interview with another MA on 12/18/19 at 3:15pm revealed: -She had never called the provider about Resident #2's low FSBS because she did not know she was suppose to. -She had never been told to call Resident #2's provider if he had frequent low FSBS. -She could always tell if Resident #2's FSBS was low because he started having behavior changes "like waving his arms around." -She would check his FSBS if she noticed him having these changes and sit with him to monitor his behavior. -She would recheck his FSBS to make sure it was still not low. -She had tried to call Resident #2's provider once related to a high FSBS but never got an answer. -She was never instructed to document when she called a resident's provider. Interview with the facility's contracted nurse on 12/19/19 at 10:15am revealed: -She had followed Resident #2 for about 6 to 7 months. -Resident #2's FSBS fluctuated throughout the month from extreme lows to highs. -She did not think Resident #2 understood how to recognize if his FSBS dropped too low. -It was important for the facility staff to monitor his FSBS to make sure Resident #2's FSBS was not dropping too low. -The facility staff was responsible for calling the provider and let him know if Resident #2 was experiencing low FSBS. Telephone interview with a nurse from Resident #2's primary care provider's office on 12/18/19 at 3:26pm revealed:	D 273		

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D 273	Continued From page 8 -The facility staff was supposed to call the provider if Resident #2's FSBS remained low after administering orange juice and having to recheck FSBS or if he had 2 to 3 low FSBS. -The office did not have any documentation that the facility had called to report Resident #2's low FSBS during the months of October, November, or December 2019. -The facility had faxed over a list of FSBS readings for Resident #2 on 05/29/19 and 08/08/19. -The provider would have changed the dose of insulin if he had known Resident #2's FSBS was dropping below 70 multiple times during a month. -Resident #2 was at an increased risk of confusion, falls, passing out, and being unresponsive if he continued to have low FSBS and his insulin dose was not adjusted. Interview with the Administrator on 12/18/19 at 2:58pm and 4:58pm revealed: -She did not know the provider was supposed to be called if Resident #2 had a low FSBS. -She thought the physician's order was only to call if Resident #2's FSBS was high. -The MAs were responsible for calling the provider if they needed to be notified regarding a resident. -She would review the physician's order with the MAs and make sure they started calling the provider if Resident #2's FSBS dropped <70. Based on observations, interviews, and record reviews, Resident #2 was not interviewable. _____ The facility failed to assure referral and follow up with the primary care provider for Resident #2 related to notifying the provider regarding frequent low blood sugar readings over the past three months with the lowest reading at 35 which	D 273		

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D 273	Continued From page 9 increased the resident's risk of confusion, falls, passing out and becoming unresponsive due to low blood sugar. This failure was detrimental to the health, safety and welfare of Resident #2 and constitutes a Type B Violation. _____ A plan of protection was requested from the facility in accordance with G.S. 131D-34 on 12/19/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 3, 2020.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a physician for 1 of 3 sampled residents (Resident #2) related to administering the incorrect dose of long acting insulin. The findings are:	D 358		

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D 358	Continued From page 10 Review of Resident #2's current FL2 dated 01/07/19 revealed diagnoses included diabetes, hypertension, mental retardation, seasonal allergies, and hyperlipidemia. Review of Resident #2's physician orders dated 10/08/19 revealed a physician's order for Basaglar (long acting insulin used to treat diabetes) inject 38 units every morning. Review of Resident #2's October 2019 Medication Administration Record (MAR) and fingerstick blood sugar (FSBS) log revealed: -There was a computer-generated entry for Basaglar inject 38 units every morning scheduled to administer at 8:00am. -There was documentation that Basaglar 40 units was administered daily from 10/01/19 to 10/31/19 at 8:00am. -From 10/01/19 to 10/31/19, Resident #2's FSBS ranged from 56 to 343 at 12:00pm, 38 to 329 at 5:00pm, and 159 to 309 at 8:00pm. Review of Resident #2's November 2019 MAR and FSBS Log revealed: -There was a computer-generated entry for Basaglar inject 38 units every morning scheduled to administer at 8:00am. -There was documentation that Basaglar 40 units was administered daily from 11/01/19 to 11/30/19 at 8:00am. -From 11/01/19 to 11/30/19, Resident #2's FSBS ranged from 87 to 378 at 12:00pm, 37 to 278 at 5:00pm, and 44 to 396 at 8:00pm. Review of Resident #2's December 2019 MAR and FSBS log revealed: -There was a computer-generated entry for Basaglar inject 38 units every morning scheduled to administer at 8:00am.	D 358		

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D 358	Continued From page 11 -There was documentation that Basaglar 40 units was administered daily from 12/01/19 to 12/18/19 at 8:00am. -From 12/01/19 to 12/18/19, Resident #2's FSBS ranged from 68 to 435 at 12:00pm, 31 to 174 at 5:00pm, and 63 to 325 at 8:00pm. Interview with a medication aide (MA) on 12/18/19 at 4:17pm revealed: -She had administered 40 units of Basaglar daily to Resident #2 for several weeks. -She remembered the doctor had adjusted the dose in the past, but it had been the same for a while. -She did not know the MAR and the label from the pharmacy on the medication listed the directions for Basaglar as 38 units every morning. -She did not remember seeing a medication order for Basaglar 38 units every morning. -She was responsible for documenting on the MAR that she administered the Basaglar daily but the dose was documented on the FSBS record sheet. -She was responsible for administering medications based on the MAR. -She was responsible for updating the MAR if she received the medication order. -The Administrator was responsible for updating and auditing the MARs monthly when the new MARs were delivered from the pharmacy Observation of Resident #2's medication on hand on 12/18/19 at 4:00pm revealed: -There was 1 partially used Basaglar pen remaining in an opened box dispensed on 10/25/19 with the directions inject 38 units every morning. -The partially used pen was not labeled with an opened date. -There was 1 unopened box of Basaglar	D 358		

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D 358	Continued From page 12 containing 5 pens dispensed on 11/27/19 with the directions to inject 38 units every morning. Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/18/19 at 4:00pm revealed: -The pharmacy had dispensed 5 pens of Basaglar to Resident #2 on 11/27/19 with the directions to inject 38 units every morning. -One box of 5 pens of Basaglar would provide 41 days of medication to Resident #2 based on the current directions. -Previously, the pharmacy had dispensed a box of Basaglar to Resident #2 on 10/25/19 and 10/01/19 with the same directions. Telephone interview with a third shift MA on 12/19/19 at 9:45am revealed: -She usually worked third shift and administered Resident #2's Basaglar in the morning. -She had administered Basaglar 40 units to Resident #2 for several weeks. -She did not know Resident #2's Basaglar order was changed to 38 units every morning. -She did not check the label on the Basaglar because she thought she knew Resident #2's dose. -The Administrator was responsible for processing new medication orders. -She rarely was able to see the medication orders for the residents. -She relied on the MAR to know what medications to administer to each resident. -She was responsible for completing a medication cart audit weekly. Interview with the contracted facility nurse on 12/19/19 at 10:15am revealed: -She followed Resident #2 for the past 6 to 7 months.	D 358		

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D 358	Continued From page 13 -Resident #2's FSBS fluctuated throughout the day from extreme lows and highs. -Resident #2 did not understand the signs and symptoms of hypoglycemia (low blood sugar). Telephone interview with a nurse from Resident #2's Primary Care Provider (PCP) office on 12/18/19 at 3:26pm revealed: -Resident #2's current medication order for Basaglar was to inject 38 units subcutaneously daily. -The facility staff was responsible for administering the correct dose of insulin to Resident #2. -It was important to follow the physician's order for insulin because too much insulin could cause hypoglycemia. -Resident #2 was at an increased risk for confusion, lightheadedness, falls, passing out and being unresponsive if he experienced hypoglycemia. Interview with the Administrator on 12/18/19 at 4:35pm and 12/19/19 at 3:10pm revealed: -Each resident's provider was responsible for faxing the medication orders to the pharmacy. -The pharmacy was responsible for sending new medication orders to the facility daily with the medication delivery. -She did not receive a medication order for Basaglar 40 units every morning for Resident #2. -The MAs should administer 38 units of Basaglar daily to Resident #2 based on the current order and the MAR. -The MAs were responsible for administering medications based on the MAR. -The MAs should be reading the MAR and the pharmacy labels before they administered a medication to make sure they are administering the correct dose.	D 358		

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D 358	Continued From page 14 -She did not look at the insulin administration sheet when she audited the MARs monthly. -She did not know the MAs were administering the wrong dose of Basaglar to Resident #2. -She had not been checking behind the MAs because she had "to much on her plate." Based on observations, interviews, and record reviews, Resident #2 was not interviewable. The facility failed to administer medications as ordered by a physician for Resident #2 related to administering the incorrect dose of Basaglar insulin for at least 3 months resulting in Resident #2 having an increased risk for hypoglycemia which could lead to confusion, lightheadedness, falls, passing out, and being unresponsive. This failure was detrimental to the health, safety and welfare of the resident and constitutes a Type B violation. A plan of protection was requested from the facility in accordance with G.S. 131D-34 on 12/19/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 3, 2020.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication	D 367		

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D 367	Continued From page 15 administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure accuracy of the Medication Administration Record (MAR) for 1 of 3 sampled residents (Resident #1) related to documentation of a medication as administered after it had been discontinued. The findings are: Review of Resident #1's current FL2 dated 09/04/19 revealed: -Diagnoses included diabetes, chronic obstructive pulmonary disease, bipolar, schizophrenia, and hypertension. -There was a physician's order for Januvia (a	D 367		

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D 367	Continued From page 16	D 367		

medication used to treat type 2 diabetes) 100mg take 1 tablet every morning at 8:00am.
-There was a physician's order for Trulicity (a medication used to treat type 2 diabetes) inject 1.5mg subcutaneously every 7 days.

Review of Resident #1's October 2019 MAR revealed:
-There was an entry for Januvia 100mg take 1 tablet every morning at 8:00am.
-Januvia was documented as administered daily from 10/01/19 through 10/31/19.

Review of Resident #1's November 2019 MAR revealed:
-There was an entry for Januvia 100mg take 1 tablet every morning at 8:00am.
-Januvia was documented as administered daily from 11/01/19 through 11/30/19.

Review of Resident #1's December 2019 MAR revealed:
-There was an entry for Januvia 100mg take 1 tablet every morning at 8:00am.
-Januvia was documented as administered daily from 12/01/19 through 12/18/19.
-Januvia was documented as discontinued on 12/19/19.

Observation of Resident #1's medications on hand on 12/18/19 at 4:40pm revealed there was no Januvia available for administration.

Interview with Resident #1 on 12/18/19 at 4:20pm revealed:
-His family member picked up his medications from the pharmacy and delivered them to the facility, but he did not know if Januvia was one of the medications.
-He did not know if he was still being

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D 367	Continued From page 17 administered Januvia. Telephone interview with a representative at the pharmacy where Resident #1 had his medications dispensed on 12/19/19 at 10:23am revealed: -Resident #1's Januvia was last dispensed on 12/07/18. -They had not received a new physician's order for Januvia for Resident #1 since 12/07/18. -They did not receive an order to discontinue Januvia and faxed the physician notifying him Resident #1 needed a new prescription or a discontinue order. -They did not have documentation of the fax sent to Resident #1's physician for clarification of Januvia. -They could not remove Januvia from the MAR until they had received an order to discontinue it. Interview with the Medication Aide (MA) on 12/19/19 at 11:08am revealed: -Resident #1 had been taking Januvia but he had just run out of the medication about 2 days ago. -She took the empty package of Januvia for Resident #1 to the Administrator on 12/17/19 or 12/18/19 so that she could request for the Januvia to be refilled. -Resident #1's family got his medications from the pharmacy and delivered them to the facility. Telephone interview with the nurse from Resident #1's Endocrinology office on 12/19/19 at 12:20pm revealed: -Januvia for Resident #1 was discontinued in January 2019 when he was changed to Trulicity. -Resident #1's physician faxed a discontinue order for Januvia to the pharmacy on 01/07/19 at 2:00pm.	D 367		

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D 367	Continued From page 18 Telephone interview with Resident #1's family member on 12/20/19 at 1:30pm revealed: -She picked up Resident #1's medications from the pharmacy and delivered them to the facility. -Resident #1's Endocrinologist stopped his Januvia in January 2019 and started him on Trulicity. -Januvia had not been dispensed from the pharmacy since December 2018 for Resident #1. -The Administrator called her on 12/18/19 and said the Januvia needed to be refilled for Resident #1 and she informed her it had been discontinued in January 2019 and sent her a copy of the order by text message. Telephone interview with the Administrator on 12/20/19 at 3:00pm revealed: -The policies and procedures for medication administration was for herself or the MA to copy the physician's order and place the copy in a notebook in the medication room; the original order was filed in the residents record, and the MAR was changed to match the physician's orders. -New medication orders were faxed from the physician's office to the pharmacy and the pharmacy would make changes to the MAR for the next month. -The pharmacy would send updated MARS at the beginning of the month. -Since Resident #1's family took him to his physician appointments, she relied on the family to give her a copy of the new orders for Resident #1. -She did not know why Januvia was still on the MAR for Resident #1 when it had been discontinued in January 2019. -She did not know why staff had documented Januvia was administered to Resident #1 when the medication was not available to administer;	D 367		

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D 367	Continued From page 19 "It's just a habit of them signing".	D 367		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 sampled residents (#1) had physician's orders to self-administer a nebulizer treatment. The findings are: Review of Resident #1's current FL2 dated 09/04/19 revealed: -Diagnoses included chronic obstructive pulmonary disease, tracheostomy, diabetes, bipolar, schizophrenia, and hypertension. -There was a physician's order for albuterol (a medication used to prevent and treat shortness of breath) 2.5mg/3ml use one vial via nebulizer every 4-6 hours as needed.	D 375		

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D 375	Continued From page 20 -There was no order to self-administer albuterol. Observation on initial tour at the facility on 12/18/19 at 9:35am revealed Resident #1 had a nebulizer machine sitting on the bedside table in his room. Interview with Resident #1 on 12/18/19 at 9:35am revealed he was taking nebulizer treatments usually twice per day. Observation of Resident #1's medications on hand on 12/18/19 at 4:00pm revealed albuterol 2.5mg/3ml vials in an opened box was available for administration. Interview with the Medication Aide (MA) on 12/18/19 at 4:00pm revealed: -Resident #1 kept some albuterol vials in his room to self-administer to himself. -She did not know if Resident #1 had an order to self-administer his albuterol nebulizer treatments. -She did not know who gave Resident #1 the albuterol to self-administer. Interview with Resident #1 on 12/18/19 at 4:20pm revealed: -He self-administered his albuterol nebulizer treatments about twice per day. -He did not know how often his albuterol nebulizer treatments were ordered. -He kept the albuterol vials in his bedside table drawer. -The MA gave him the albuterol vials to keep in his room. -He did not use the facility's contracted pharmacy to dispense his medications. -His family member took him to all his scheduled physician appointments and picked up his medications from the pharmacy and delivered	D 375		

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D 375	Continued From page 21	D 375		

them to the facility.

Observation of Resident #1 on 12/18/19 at 4:22pm revealed:
-Resident #1 opened his bedside table drawer and removed some plastic vials and put them on the top of the table.
-There were 13 clear colored plastic vials labeled as albuterol sulfate.

Review of Resident #1's October 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for albuterol 2.5mg/3ml one vial via nebulizer every 4-6 hours as needed.
-There was no documentation on the eMAR indicating the albuterol was self-administered.

Review of Resident #1's November 2019 eMAR revealed:
-There was an entry for albuterol 2.5mg/3ml one vial via nebulizer every 4-6 hours as needed.
-There was no documentation on the eMAR indicating the albuterol was self-administered.

Review of Resident #1's December 2019 eMAR from 12/01/19 through 12/18/19 revealed:
-There was an entry for albuterol 2.5mg/3ml one vial via nebulizer every 4-6 hours as needed.
-There was no documentation on the eMAR indicating the albuterol was self-administered.

Telephone interview with a representative from the pharmacy where Resident #1's medications were dispensed from on 12/20/19 at 2:46pm revealed:
-Resident #1's Albuterol was last dispensed on 01/08/16 in the amount of 100 vials.
-The last physician order faxed to the pharmacy for albuterol for Resident #1 was on 01/08/16.

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D 375	Continued From page 22 -He did not know if the Albuterol had expired since he was not able to look at the medication. Telephone interview with a nurse for Resident #1's physician's office on 12/20/19 at 2:50pm revealed: -The last physician's order for albuterol 2.5mg/3ml 100 vials with 3 refills for Resident #1 was written and faxed to a second pharmacy on 06/04/19 by the request of Resident #1. -Resident #1's physician was not aware Resident #1 was self-administering his albuterol nebulizer treatments. -Resident #1 did not have documentation of a physician's order to self-administer his albuterol nebulizer treatments. Telephone interview with the Administrator on 12/20/19 at 3:00pm revealed: -She was not aware Resident #1 had medication in his room that he self-administered. -She did not know who had given albuterol to Resident #1 to keep in his room. -Resident #1 did not have an order to self-administer albuterol nebulizer treatments to himself. -Resident #1 had not asked for an albuterol nebulizer treatment "in a very long time".	D 375		
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.	D912		

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D912	Continued From page 23	D912		

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to assure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules related to health care and medication administration.

The findings are:

1. Based on observations, interviews, and record reviews, the facility failed to notify the physician for 1 of 3 sampled residents (Residents #2) related to notifying the physician regarding frequent low fingerstick blood sugar readings [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care Referral and Follow Up (Type B Violation)].

1. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a physician for 1 of 3 sampled residents (Resident #2) related to administering the incorrect dose of long acting insulin [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].