STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and a COVID-19 focused Infection Control survey with an onsite visit on September 15, 2020 and a desk review survey on September 15, 2020 to September 18, 2020; September 21, 2020 to September 24, 2020 and a telephone exit on September 24, 2020.	{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: Based on interviews and record reviews, the facility failed to ensure notification of the primary care provider (PCP) for 1 of 5 sampled residents (#2) when the resident had a weight loss of 6 pound from August 2020 to September 2020. The findings are: Review of Resident #2's current FL-2 dated 08/20/20 revealed: -Diagnoses included dementia, fracture of the left femur, falls, muscle weakness, coronary obstructive pulmonary disease, depression, gastroesophageal reflux disease, a history of transient ischemic attacks and cerebrovascular accident. -The resident was constantly disoriented. -The resident's recommended level of care was a special care unit (SCU). -There was an order for monthly weights on the 2nd of each month.	{D 273}		

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Review of Resident #2's July 2020 electronic medication administration record (eMAR) revealed:
-There was an entry for monthly weights, scheduled once a day on the 2nd of the month.
-There was documentation the resident weighed 121.8 pounds (lbs) on 07/02/20.

Review of Resident #2's August 2020 eMAR revealed:
-There was an entry for monthly weights, scheduled once a day on the 2nd of the month.
-There was a medication aide's (MA's) initials with parenthesis around the initials with no weight documented on 08/02/20.
-There was no other entry for the resident's monthly weight.

Review of an electronic hospital form labeled "Summary-Indicators" for Resident #2 revealed:
-The resident's weight was documented as 117.07 lbs on 08/13/20.
-There was a handwritten entry which read "Aug weights per PCP" (primary care provider).

Review of Resident #2's September 2020 eMAR revealed:
-There was an entry for monthly weights, scheduled once a day on the 2nd of the month.
-There was documentation the resident weighed 111 lbs on 09/02/20.

Telephone interview with the Administrator on 09/21/20 at 2:26pm revealed:
-A 6 lb weight loss was a significant change.
-The MA's initials with parenthesis documented on Resident #2's eMAR on 08/02/20 meant the weight was not done.
-Resident #2's weight on 08/13/20 was obtained from the hospital and she thought the primary

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care provider (PCP) obtained the resident's weight.

Telephone interview with the Memory Care Manager (MCM) on 09/21/20 at 2:26pm revealed:
-She was not aware the resident had a 6 lb weight loss in September 2020.
-She was responsible for performing resident record audits weekly.
-During record audits the residents' current FL-2 and orders were reviewed to ensure the orders were carried out.
-Resident #2's PCP should have been notified of the 6 lb weight loss from 08/13/20 - 09/02/20 and there was no documentation Resident #2's PCP was notified concerning Resident #2's weight loss in September 2020.
-The MA who weighed the resident would have been responsible for notifying the PCP when the resident was weighed and had a 6 lb weight loss, then the MA should have notified her.

Telephone interview with a personal care aide (PCA) on 09/23/20 at 9:46am revealed
-The MAs were responsible for weighing the residents but the PCAs helped with the residents' weights when they were needed.
-Resident #2 had lost weight recently and she noticed the resident's clothes appeared "big" on the resident.

Telephone interview with a MA on 09/23/20 at 12:54pm revealed the MAs were responsible for notifying the residents' PCP when there was a 5 lb weight loss or weight gain.

Telephone interview with Resident #2's family member on 09/23/20 at 8:26am revealed:
-The resident had been diagnosed with COVID-19 in July 2020.

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{D 273}	Continued From page 3 -The family member estimated the resident had lost approximately 40 lbs since the pandemic of COVID-19 occurred in March 2020. Telephone interview with Resident #2's PCP on 09/18/20 at 10:20am revealed: -She had not been notified by the facility that the resident's weight was down 6 lbs on 09/02/20 which was a significant weight change. -She expected staff to notify her when a resident had a weight loss over 5 lbs. -If she had received notification of Resident #2's 6 lb weight loss on 09/02/20, she could have increased his supplements. -It was important to inform her of the resident's weight loss because the resident had been diagnosed with COVID-19 which caused decreased appetite and a loss of taste due to not feeling good. -Resident #2's weight loss could be seen by a visual observation of the resident. -Resident #2 had a weight of 118 lbs on 07/15/20. Telephone interview with the MCM on 09/22/20 at 4:02pm revealed: -Resident #2 had lost "a lot" of weight since August 2020. -The MAs were responsible to notify the resident's PCP when any resident lost or gained 5 lbs. -She confirmed that the initials on the eMAR for Resident #2's weight on 09/02/20 were her initials. -She did not contact Resident #2's PCP to report the 6 lb weight loss. -When there was a significant weight change in the residents' weight, the eMAR system gave staff an alert with the weight in red when the new weight was entered. -The residents' weights were documented in the	{D 273}		

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eMAR system as a "baseline" weight and a "routine" weight but, weights should have been entered monthly as routine after the initial baseline weight.
-She thought Resident #2's monthly weights had not been entered as routine each month.
-The eMAR system would have displayed an alert on 09/02/20 if Resident #2's previous weights had been entered into the eMAR system as routine.
-She did not remember receiving an alert from the eMAR system on 09/02/20 when she entered Resident #2's weight but, if she had received an alert then she would have notified the resident's PCP.
-Resident #2's previous weight would not have shown up on the eMAR when Resident #2's weight was documented on 09/02/20 as 111 lbs but, the resident's previous weights could have been accessed in the eMAR system and the difference calculated between the resident's current and previous weight.
-She did not know why Resident #2's weight loss of 6 lbs was not reported to the PCP.
-Resident #2's weight today (09/22/20) was 112.5 lbs.

Telephone interview with the Administrator on 09/23/20 at 3:35pm revealed:
-Resident #2 had been diagnosed with COVID-19 around the end of July 2020 or the first of August 2020 and the resident was not eating as well during that time.
-She was aware of the order for Resident #2 to be weighed monthly because all the residents at the facility had standing orders for monthly weights.
-She was not aware Resident #2 had a 6 lb weight loss from August 2020 to September 2020.
-Resident #2's weight loss of 6 lbs was

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{D 273}	Continued From page 5 "significant". -Resident's #2's PCP should have been notified by the MA when the resident had a 6 lb weight loss on 09/02/20. -The MCM would have been responsible to follow-up to ensure the weight loss was addressed by the PCP. -It was the facility's process to notify the PCP when a resident lost 5% of weight in 30 days or 10% in 60 days. Based on interviews and record reviews, Resident #2 was not interviewable.	{D 273}		
{D 276}	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews the facility failed to ensure physician's orders were	{D 276}		

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implemented for 2 of 5 sampled residents for daily weights with parameters for medication that was to be given according to the daily weights (#5) and a urine swab (#2).

The findings are:

Based on interviews and record reviews the facility failed to ensure physician's orders were implemented for 2 of 5 sampled residents for daily weights with parameters for medication that was to be given according to the daily weights (#5) and a urine swab (#2).

The findings are:

1.Review of Resident #5's current FL-2 dated 07/06/20 revealed:
-Diagnoses included dementia, atrial fibrillation, congestive heart failure, hypertension, coronary artery disease, diabetes mellitus and cardiomyopathy.
-The resident was constantly disoriented.
-There was an order for daily weights and report weight gain greater than 3 pounds in 1 day or 5 pounds in a week.

Review of Resident #5's July 2020 electronic Medication Administration Record (eMAR) revealed:
-There was a computer-generated entry for daily weights and report weight gain greater than 3 pounds in a day or 5 pounds in a week.
-There was no documentation of weights for 14 out of 26 days, on 07/08/20-07/15/20, 07/19/20, 07/22/20, 07/24/20, 07/27/20, 07/29/20 and 07/31/20.
-There was documentation on the exception log on 07/08/20, 07/13/20, 07/19/20 and 07/31/20 that Resident #5 refused.

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{D 276}	Continued From page 7 -There was documentation on the exception log on 07/09/20, 07/14/20, 07/22/20 and 07/27/20 that Resident #5 was sleeping. -There were no weights documented on the exception log on 07/10/20-07/12/20, 07/15/20, 07/24/20 and 07/29/20. -Resident #5's weight on 07/06/20 was 176.4lbs and 185.8lbs on 07/07/20, 9.4-pound weight gain. -Resident #5's weight on 07/17/20 was 185lbs and 189lbs on 07/18/20 , 4-pound weight gain. -Resident #5's weight on 07/25/20 was 183.5lbs and 191.2lbs on 07/26/20 , 7.7-pound weight gain. Review of Resident #5's August 2020 eMAR revealed: -There was a computer-generated entry for weights daily and report weight gain greater than 3 pounds in a day or 5 pounds in a week. -There was no documentation of weights 4 out of 31 days, 08/01/20-08/04/20. -There was documentation on the exception log on 08/01/20 that Resident #5 was sleeping. -There was documentation on the exception log on 08/02/20 that Resident #5 refused. -There was no documentation on the exception log on 08/03/20. -There was documentation on the exception log on 08/04/20 that Resident #5 was in the emergency department (ED). -Resident #5's weight on 08/25/20 was 173lbs and 189lbs on 08/26/20, 16-pound weight gain. Telephone interview with Resident #5's primary care physician (PCP) on 09/18/20 at 8:20am revealed: -The facility did not weigh the resident according to the order. -She had not been notified of the resident not	{D 276}		

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being weighed.
-She would see if it was done by looking at the eMAR.
-She had not been notified of any weight changes for the residents.
-She would expect to be notified if Resident #5's weight "stayed up" or if the resident had shortness of breath.
-Her expectation was for the order for daily weights to be followed.
-It could put her at risk for having an exacerbation of congestive heart failure.

Telephone interview with a personal care aide (PCA) on 09/18/20 at 4:32pm revealed:
-The medication aide (MA) and the PCAs were responsible for obtaining the residents' weights.
-The MAs were responsible for documenting the weights in the computer.
-She reported residents' weights to the MA.
-She did not know who was responsible for notifying the PCP of weights outside of ordered parameters.

Telephone interview with the Administrator on 09/21/20 at 2:26pm revealed:
-The facility weight policy followed the state guidelines.
-The PCAs obtained the weights and gave them to the MA, and the MA documented them on the eMAR.
-She could not justify why Resident #5's weights were not obtained as ordered.
-Her expectation was for the weights to be obtained and documented on the eMAR.
-The MA was responsible for notifying the PCP of any weight change according to ordered parameter or if the resident did not get weighed.
-There was a facility report that was run daily, that captured the tasks that were completed the day

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before and flagged what was not completed.
-She did not know why the daily report was not being done.
-The Memory Care Manager (MCM) and the Resident Care Manager (RCM) were responsible for reviewing the reports and making sure the weights were obtained.

Telephone Interview with a MA on 09/21/20 at 5:05pm revealed she was aware Resident #5 had a daily weight order.

Telephone interview with another MA on 09/22/20 at 3:07pm revealed:
-To weigh Resident #5, she pulled the wheelchair up to the scale and then helped her stand up on the scale.
-Resident #5 had edema in her legs and "sometimes there is no difference between where her ankles start and stop."
-Resident #5 would get short of breath at times.
-She had never noticed the resident being short of breath at rest.
-If a shift was unable to obtain a weight then it should have been passed on to the next shift and it should be written in the progress notes.
-There was no reason an order should not be completed unless the resident was out of the building and then it should have been documented in the progress notes.

Telephone interview with the Memory Care Manager (MCM) on 09/22/20 at 4:38pm revealed:
-She confirmed that the initials on the eMAR for daily weights on 08/26/20 were her initials.
-She was not aware there had been a 16-pound weight gain documented from 08/25/20-08/26/20.
-The previous weight did not show up on the eMAR.
-She did not look at the previous weight because

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an alert did not pop up on the eMAR.
-The weights had to be put in under routine in the eMAR system for there to be an alert.
-The weight on 08/25/20 was put in under baseline and on 08/26/20 was put in under routine.
-When an alert popped up then the MA must look back at the previous weight to see if there was a weight gain.

Telephone interview with another PCA on 09/23/20 at 9:46am revealed:
-The MAs were responsible for weighing the residents but the PCAs helped with the weights when they were needed.
-Weights could be obtained anytime of the day.
-If the residents were asleep or refused, they would try again later to get their weight.
-She did not know how often Resident #5 was supposed to be weighed.

Telephone Interview with another PCA on 09/23/20 at 12:18pm revealed:
-Resident #5 was weighed daily in the mornings.
-MAs and PCAs weighed her together.
-She did not know the number of pounds of weight gain supposed to be reported to the PCP.

Telephone interview with another MA on 09/23/20 at 12:54 revealed:
-When the weights were entered into the eMAR it should be documented under routine weights.
-Baseline weights were only supposed to be used as the initial weight.
-She thought it would come up as an alert if there was a weight gain.
-She had never had it alert regarding weigh gain for Resident #5.

Telephone interview with the Administrator on

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{D 276}	Continued From page 11 09/23/20 at 3:35pm revealed: -On 08/26/20, when Resident #5 weighed 189 lbs and the resident's prior weight was 173lbs on 08/25/20, the eMAR system should have flagged the resident's weight of 189lbs as an alert in a red colored font. -The residents' weights were entered into the facility's eMAR system two ways, under a baseline weight or routine weight. -The residents' initial weight should have been entered as a "baseline" weight and all weights thereafter should have been entered as "routine" weights in the facility's eMAR system. -When residents' weights were entered as "baseline", the system recognized the weight as new and would not have alerted a change in the residents' weight. -When Resident #5's order for daily weights to report a 3lb weight gain in one day or a 5lb weight gain in one week was entered into the facility's eMAR system, there was documentation to report when the resident's weight was out of the ordered parameters. Based on interviews and record reviews, it was determined Resident #5 was not interviewable. Refer to the review of the facility's Bucket System. 2. Review of Resident #2's current FL-2 dated 08/20/20 revealed: -Diagnoses included dementia, fracture of the left femur, falls, muscle weakness, coronary obstructive pulmonary disease, depression, gastroesophageal reflux disease, history of transient ischemic attacks and cerebrovascular accident. -The resident was constantly disoriented. -The resident's recommended level of care was a	{D 276}		

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{D 276}	Continued From page 12 special care unit (SCU). Review of Resident #2's current Assessment and Care Plan dated 06/25/20 revealed: -The resident was sometimes disoriented. -The resident required limited staff assistance with eating and required extensive staff assistance with toileting, ambulation, bathing, dressing, grooming and transferring. Review of Resident #2's electronic progress notes revealed: -On 07/30/20 at 12:23am, there was an entry the resident was not feeling well, and the resident's vital signs would be monitored. -On 08/03/20 at 4:26am, there was an entry the resident needed assistance eating and drinking. Review of a primary care provider's (PCP's) consultation note for Resident #2 dated 08/03/20 revealed: -The resident's diagnosis included COVID-19 and to report any new or uncontrolled symptoms so the resident's symptoms could be managed. -There was an entry to obtain a urine swab to rule out a urinary tract infection (UTI) with possible decreased fluid intake and increased disorientation. Review of a PCP order for Resident #2 dated 08/03/20 revealed an order for a urine swab and to notify the PCP's office when the urine swab sample was ready. Review of Resident #2's electronic progress notes revealed: -On 08/08/20 at 12:35am, the resident was very confused when given his medication, "almost like he couldn't remember how to open his mouth". -On 08/08/20 at 4:57pm, the resident did not eat	{D 276}		

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{D 276}	Continued From page 13	{D 276}		

much of his meals but drank all fluids plus "shakes".
-On 08/09/20 at 11:38pm, there was an entry the resident said he felt "lousy".
-On 08/13/20 at 11:44am, the PCP sent the resident to the emergency department (ED) due to abnormal labs.
-There was no entry the resident's urine swab order had been attempted or completed.

Telephone interview with a personal care aide (PCA) on 09/23/20 at 9:46am revealed:
-The medication aides (MAs) were responsible for obtaining the residents' urine specimens when ordered.
-Resident #2 was "a little more confused" and was not eating and drinking as much around the end of July 2020 through the first of August 2020, however, she was not aware of any other signs or symptoms of a UTI that Resident #2 was having.

Telephone interview with a MA on 09/23/20 at 12:54pm revealed:
-The MAs were responsible for collecting urine swabs when ordered.
-She was not aware of an order dated 08/03/20 for Resident #2 to have a urine swab.
-The managers (The Resident Care Manager (RCM) and the Memory Care Manager (MCM) were responsible to ensure the residents' orders were in the Bucket System and the orders were carried out.

Telephone interview with the MCM on 09/21/20 at 2:26pm revealed:
-She was not aware Resident #2 had an order for a urine swab on 08/03/20.
-The urine swab order written on 08/03/20 included additional orders that were completed for Resident #2, so she was not sure why only

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{D 276}	Continued From page 14	{D 276}		

"certain parts" of the order was implemented and the urine swab wasn't.
-When PCP orders were received, the PCP's orders went into a Bucket System, meaning the orders were placed in color coded folders until the order had been completed and filed in the resident's record.
-She and the RCM were responsible for ensuring the orders were processed and completed by using the Bucket System.
-Resident #2's PCP placed all orders for the facility to complete in a book located in the MCM's office.
-The RCM was responsible for ensuring orders were completed in the SCU in her absence.
-She performed record audits weekly by reviewing the residents' current FL-2 and the PCP's orders to ensure the orders were carried out.
-She was not sure if a record audit had been completed for Resident #2 after 08/03/20.

Telephone interview with the Administrator on 09/21/20 at 2:26pm revealed:
-The MCM and the RCM were responsible for completing five resident record audits per week.
-She expected for the urine swab for Resident #2 to have been completed as ordered.
-If Resident #2's urine swab could not been obtained, she expected staff to notify the resident's PCP and expected staff to have documented the PCP's notification in Resident #2's record.

Telephone interview with the MCM on 09/22/20 at 4:02pm revealed:
-She had reviewed Resident #2's record and was not sure why the urine swab order dated 08/03/20 was missed.
-The MAs were responsible for pulling Resident

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{D 276}	Continued From page 15 #2's order to obtain the urine swab and contacting the lab to have the urine swab picked up. -Once Resident #2's lab result were received, the order would have been filed into the "green folder" meaning the order had been completed and ready to be filed into the resident's record. -The MAs were responsible for checking the residents' orders placed in the "blue" folder of the Bucket System every shift. -She was responsible to check the Bucket System folders every morning to ensure the order had been done and moved into to another folder. Telephone interview with the Administrator on 09/23/20 at 3:35pm revealed: -The MAs were responsible for collecting Resident #2's urine swab and contacting the laboratory to pick up the sample from the facility. -All orders were processed using the Bucket System to ensure all orders were implemented. -All lab orders were placed in a blue folder until the lab results were completed and reviewed by the PCP. -Once the lab results had been completed and the PCP had received and reviewed the lab results, the order was then filed into the residents' record as completed. -She was not aware Resident #2 had an order for a urine swab dated 08/03/20. -Resident #2's urine swab order should have been processed through the Bucket System. -She was not sure why the order for Resident #2's urine swab was not implemented. -She expected for Resident #2's urine swab to have been done the same day the order was received and if staff had not been able to collect the sample, then it should have been reported to the next shift to perform. Telephone interview with Resident #2's PCP on	{D 276}		

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{D 276}	Continued From page 16 09/18/20 at 10:20am revealed: -The resident's urine swab was never received from the order given to the facility on 08/03/20. -She ordered the urine swab because the resident was not drinking as much fluids and was having increased disorientation and not acting his "normal self". -She thought the resident possibly could have had an infection that was not being treated, which was causing symptoms and she ordered the urine swab to rule out a UTI. -On 08/03/20, the resident was lying around more which was not his normal and was having decreased fluid intake which placed the resident at risk for dehydration. -UTIs could have affected the resident by causing the resident to have a worsening mental status, and if the resident had an infection in the body, the infection could have worsened. -A UTI would have placed the resident at increased risk of falls and increased confusion. -The resident was admitted to the hospital 10 days after the order was written for a urine swab with a diagnosis of pneumonia, however, there was no urinalysis done while the resident was hospitalized. Based on interviews and record reviews, Resident #2 was not interviewable Refer to the review of the facility's Bucket System. _____ Review of the facility's Bucket System revealed: -There were 5 colored folders labeled as a numbered "Bucket". -All new physician's orders that required faxing to the facility's contracted pharmacy provider and were awaiting to appear in the facility's electronic medication administration record's (eMAR's)	{D 276}		

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{D 276}	Continued From page 17 system were placed in "Bucket #1-yellow". -All new orders that had populated into eMAR system and the medication had not arrived from the facility's contracted pharmacy was placed in the "Bucket #2-orange". -All medications not delivered were incomplete, required physician clarification, needed a hard copy, or required authorization were placed in "Bucket #3- red". -All laboratory, diet, durable medical equipment, oxygen therapy, hospital follow-up and miscellaneous orders requiring follow-up by the facility with another clinical/support service group were placed in "Bucket #4- blue". -All orders processed, medications received from the order and physician orders implemented and ready to be filed in the resident's chart were placed in "Bucket #5- green". _____ The facility failed to ensure implementation of a daily weight order for Resident #5, who was diagnosed with congestive heart failure (CHF) and frequently had lower leg edema and complained of shortness of breath. The resident was not weighed daily on 18 dates from 07/07/20 - 08/31/20 without primary care provider (PCP) notification which placed the resident at increased risk for missed doses of a diuretic ordered as need for weight gain and CHF exacerbation; and failed to obtain a urine swab as ordered by the PCP for Resident #2 who was having increased disorientation and decreased fluid intake which placed the resident at an increased risk for falls and increased confusion. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/21/20 with an addendum on 09/22/20.	{D 276}		

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{D 276}	Continued From page 18 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 8, 2020	{D 276}		
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 interviews and record reviews the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#5) related to Bumex 0.5mg being administered as needed for weight gain. The findings are: Review of Resident #5's current FL-2 dated 07/06/20 revealed: -Diagnoses included dementia, atrial fibrillation, congestive heart failure, hypertension, coronary artery disease, diabetes mellitus and cardiomyopathy. -The resident was constantly disoriented. -There was an order for Bumex tablet 0.5 mg take 1 tablet everyday as needed for weight gain	D 358		

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D 358	Continued From page 19 more than 3 pounds (lb) in a day or 5lb in a week. (Bumex is a diuretic used to treat fluid retention). Review of Resident #5's July 2020 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for Bumex tablet 0.5 mg take 1 tablet everyday as needed (PRN) for weight gain more than 3 pounds in a day or 5lb in a week. -There was no documentation of Bumex was administered to Resident #5 on 07/07/20 for a 9.4lb weight gain. -There was no documentation of Bumex was administered to Resident #5 on 07/18/20 for a 4lb weight gain. -There was no documentation of Bumex was administered to Resident #5 on 07/26/20 for a 7.7lb weight gain. Telephone interview with a medication aide (MA) on 09/21/20 at 5:05pm revealed: -She was familiar with Resident #5's PRN Bumex order that was to be given for more than a 3lb weight gain in 1 day. -She had not administered Resident#5's Bumex "lately." -She had not called the PCP regarding Resident #5's weight gain. -She could not recall if she gave Bumex on 07/18/20 for the 4lb weight gain. -There were days Resident #5 had swelling in her legs. Review of Resident #5's August 2020 eMAR revealed: -There was a computer-generated entry for Bumex tablet 0.5 mg take 1 tablet everyday as needed for weight gain more than 3lb in a day or 5lb in a week.	D 358		

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D 358	Continued From page 20 -There was no documentation Bumex was administered to Resident #5 on 08/26/20 for a 16lb weight gain overnight. -There was no documentation Resident#5's primary care provider (PCP) had been notified. Telephone interview with Resident #5's PCP on 09/18/20 at 8:20am revealed: -She would expect to be notified if Resident #5's weight "stayed up" or if the resident had shortness of breath. -She expected the facility to follow the order and administer Bumex if Resident #5 had a weight gain of more than 3lb in a day. -Resident #5 frequently had lower extremity edema. -If the order for daily weights and administration of Bumex was not followed Resident #5 could go into congestive heart failure. Telephone interview with the Administrator on 09/21/20 at 2:26pm revealed: -She did not know why Resident #5's Bumex order was not followed. -If there was no documentation for Bumex on the eMAR then the MAs did not administer the Bumex. -She did not know if the PCP was notified about the Bumex not being given when needed. -She expected the order to be followed. Telephone interview with the Memory Care Manager (MCM) on 09/22/20 at 4:38pm revealed: -She did not administer Bumex on 08/26/20 after weighing Resident #5. -There was no alert on the eMAR system and she did not check the previous weight. -The Bumex order would not have come up when the weight was put in.	D 358		

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D 358	Continued From page 21 Telephone interview with another MA on 09/22/20 at 3:07pm revealed when Resident #5 had a 3lb weight gain she was to be administered Bumex 0.5mg. Telephone interview with the Administrator on 09/23/20 at 3:35pm revealed: -The MA that entered the weight should have known the administration of Bumex 0.5mg was needed as ordered and to contact the PCP. -She thought Resident #5's order for Bumex 0.5mg as needed was not followed because at times, the MAs were entering the resident's weight into the system incorrectly by entering a baseline weight instead of routine weights, however, she did not think this was "whole problem". -Resident #5's Bumex 0.5mg order was listed under the prn medications and did not automatically "pop-up" when the Bumex 0.5mg was indicated for the resident's weight gain. -When Resident #5's order for daily weights to report a 3lb weight gain in one day or a 5lb weight gain in one week was entered into the facility's eMAR system, the entry did not include the Bumex prn order and only to report when the resident's weight was out of the ordered parameters. -When MAs were not familiar with Resident #5 and her orders, it was possible some MAs might not have known the resident had an order for Bumex 0.5mg prn with parameters. -When a medication order was received, the MA on duty or the managers [The Memory Care Manager (MCM) or the Resident Care Manager (RCM)] were responsible for faxing the medication order to the pharmacy. -The facility's contracted pharmacy provider entered the medication order into the eMAR system.	D 358		

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-The new medications added to the eMAR by the facility's contracted pharmacy were "flagged".
-The MCM or the RCM was responsible for reviewing and approving the flagged medication orders in the eMAR system.
-Once approved, the order would link to the resident's eMAR and the MA could administer the medication and could document the administration.
-The residents' order would go through the facility's "Bucket System" until the order is processed and ready to be filed in the residents' record.
-The MAs, MCM and the RCM were responsible to review the orders in the Bucket system daily.

Review of the facility's Bucket System revealed:
-There were 5 colored folders labeled as a numbered "Bucket".
-All new physician's orders that required faxing to the facility's contracted pharmacy provider and were awaiting to appear in the facility's electronic medication administration record's (eMAR's) system were placed in "Bucket #1-yellow".
-All new orders that had populated into eMAR system and the medication had not arrived from the facility's contracted pharmacy was placed in the "Bucket #2-orange".
-All medications not delivered were incomplete, required physician clarification, needed a hard copy, or required authorization were placed in "Bucket #3- red".
-All laboratory, diet, durable medical equipment, oxygen therapy, hospital follow-up and miscellaneous orders requiring follow-up by the facility with another clinical/support service group were placed in "Bucket #4- blue".
-All orders processed, medications received from the order and physician orders implemented and ready to be filed in the resident's chart were

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D 358	Continued From page 23 placed in "Bucket #5- green". _____ The facility failed to administer a diuretic to Resident #5 who had diagnoses including congestive heart failure and cardiomyopathy and symptoms of weight gain, shortness of breath and lower extremity edema and was ordered Bumex 0.5 mg as needed with parameters for weight gain . There were 4 times from 07/07/20 - 08/26/20 when the resident had a weight gain ranging from 4 pounds - 16 pounds within 24 hours and was not administered Bumex as per ordered parameters. The facility's failure placed Resident #5 at increased risk for worsening symptoms and an exacerbation of congestive heart failure which was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/07/20. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 8, 2020.	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:	{D912}		

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{D912}	Continued From page 24 Based on record review and interviews, the facility failed to assure provision of adequate and appropriate care and services to residents as related to health care and medication administration. The findings are: 1. Based on interviews and record reviews the facility failed to ensure physician's orders were implemented for 2 of 5 sampled residents for daily weights with parameters for medication that was to be given according to the daily weights (#5) and a urine swab (#2). [Refer to Tag D276, 10A NCAC 13F .0902(c) Health Care (Type B Violation)]. 2. Based on interviews and record reviews the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#5) related to Bumex 0.5mg being administered as needed for weight gain. [Refer to Tag D358, 10A NCAC .1004(a) Medication Administration (Type B Violation)].	{D912}		