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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey on May 4- 7, 10 and 11, 2021.	D 000		
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 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 1 sampled staff had two-step testing for tuberculosis upon hire in compliance with control measures adopted by the Commission for Public Health. The findings are: Review of Staff E's personnel record revealed: -Staff E was hired on 01/13/21 as a medication aide (MA). -The tuberculosis (TB) screening form for Staff E did not have documentation of testing for TB skin testing. -There was no documentation of TB skin testing results for Staff E.	D 131		

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D 131	Continued From page 1 Interview with the Quality Assurance Nurse (QAN) on 05/11/21 at 4:30pm revealed there was no TB test results on record for Staff E. Interview with the Business Office Manager (BOM) on 05/11/21 at 8:30pm revealed: -She and the Administrator did an audit in April 2021 of staff personnel records; she did not remember the exact date. -She found out at that time Staff E did not have TB skin testing done. -She contacted the Licensed Health Professional Support (LHPS) Nurse on 05/07/21 to arrange TB skin testing for Staff E. Interview with the Administrator on 05/11/21 at 7:47pm revealed: -The BOM was responsible for ensuring newly hired staff had TB skin testing documentation. -When staff needed TB skin tests done, the BOM let the LHPS Nurse know. -She did not know Staff E had not had TB skin testing done until 05/07/21. Attempted telephone interview with Staff E on 05/11/21 at 5:46pm was unsuccessful.	D 131		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the 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	D 234		

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the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure tuberculosis (TB) skin testing had been completed upon admission for 2 of 5 sampled residents (#1, #4).

The findings are:

1. Review of the current FL2 for Resident #1 dated 05/05/21 revealed diagnoses included hypertension, peripheral vascular disease (PVD), immobility, congestive heart failure (CHF), weakness and anemia.

Review of the Resident Register for Resident #1 revealed she was admitted on 11/13/18.

Review of Resident #1's resident record for revealed:
-There was documentation of a tuberculin (TB) skin test that was placed on 11/01/18 and read on 11/03/18 with negative results.
-There was no documentation of a second TB skin test since admission to the facility for Resident #1.

Review of documentation provided by the facility on 05/10/21 revealed that a TB skin test had been administered to Resident #4 on 05/10/21.

Attempted interview with the RCC on 05/10/21 and 05/11/21 was unsuccessful.

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D 234	Continued From page 3 Refer to interview with the Administrator on 05/11/21 at 7:45pm. 2. Review of the current FL2 for Resident #4 dated 12/23/21 revealed diagnoses included Coronary artery disease (CAD), congestive heart failure (CHF) and gastroesophageal reflux disease (GERD). Review of the Resident Register for Resident #4 revealed he was admitted 08/16/18. Review of Resident #4's resident record revealed: -There was documentation of a tuberculin (TB) skin test that was placed on 08/16/18 and read on 08/18/18 with negative results. -There was no documentation of a second TB skin test since admission to the facility for Resident #4. Review of documentation provided by the facility on 05/10/21 revealed that a TB skin test had been administered to Resident #4 on 05/10/21. Attempted interviews with the RCC on 5/10/21 and 5/11/21 were unsuccessful. Refer to interview with the administrator on 05/11/21 at 7:45pm. _____ Interview with the administrator on 05/11/21 at 7:45pm revealed the Resident Care Coordinator was responsible for ensuring a 2 step TB skin tests were completed for each resident upon admission.	D 234		

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D 269	Continued From page 4	D 269		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure staff assisted 1 of 6 sampled residents (#6) who required personal care assistance with toileting and hand washing. The findings are: Review of Resident #6's current FL-2 dated 05/02/20 revealed diagnosis included type II diabetes mellitus. Review of Resident #6's current care plan dated 03/06/21 revealed: -Resident #3 was ambulatory with walker. -Resident #3 had limited range of motion of his right arm. -Resident #3 had bowel and bladder incontinence. -Resident #3 was disoriented, forgetful and needed reminders. -Resident #3 was totally dependent on staff with meals and required extensive assistance with toileting, bathing and dressing. Observations of a shared bathroom between resident rooms 219 and 220 on 05/04/21 at	D 269		

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D 269	Continued From page 5 11:35am revealed: -The hand bar on the wall beside the toilet had feces smeared in two areas wrapped around the bar. -There was feces smeared on the flush handle on the toilet. -The door jam above the level of a doorknob had feces smeared in two small fingerprint sized areas. -There was feces smeared on the side of the sink basin and on the faucet handle. Interview with a housekeeper on 05/04/21 at 3:00pm revealed: -He had cleaned the shared bathroom between resident rooms 219 and 220. -He checked that bathroom three times a day; Resident #6 "had some good days and some not" related to getting feces on commonly touched areas in the bathroom. Interview with the Administrator on 05/04/21 at 3:33pm revealed: -Resident #6's shared bathroom was a known problem. -Housekeeping staff checked the bathroom and personal care aides (PCAs) checked Resident #6's bathroom every hour. -The PCA reported cleaning needs to the housekeeper. -She did random monitoring during the day to check behind the housekeeper. -Resident #6's bathroom was cleaned the morning of 05/04/21 after his shower. -Resident #6 used the bathroom between being showered and lunch time. -Resident #6 needed staff assistance with personal hygiene and hand hygiene after toileting. -There was no specific direction given for Resident #6 and hand hygiene after toileting and	D 269		

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D 269	Continued From page 6 before meals. Observations of Resident #6 on 05/05/21 at 8:32am revealed: -Resident #6 was lying in the bed; there were brown smears on the white bed sheets. -Resident #6 had a dried brown substance around the cuticles of his nail beds and under the nails of the right hand; there was a fecal odor noted around the resident's hands. Review of the World Health Organization (WHO), human feces contains bacteria which can include Escherichia coli, cholera, shigella and hepatitis and can be spread person to person and on surfaces. Interview with Resident #6 on 05/05/21 at 8:32am revealed: -He had breakfast in the dining room that morning (05/05/21). -No one helped him wash his hands before breakfast that morning. -No one usually helped him wash his hands. Interview with a PCA on 05/05/21 at 8:35am revealed: -PCAs checked Resident #6 every two hours and made sure his hands were kept clean. -PCAs checked Resident #6's hands before and after meals. -She did not help Resident #6 that morning (05/05/21) before breakfast because she was not working that hall at the time. -She did not know who was working. Interview with a medication aide (MA) on 05/05/21 at 8:37am revealed: -PCAs and MAs checked Resident #6's clothing and bathroom for cleanliness.	D 269		

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D 269	Continued From page 7 -She normally saw Resident #6 on arrival to work sitting in the TV room or the dining room; she did not see him that morning (05/05/21). -She did not see Resident #6 until he came to the medication cart after breakfast. -She did not notice Resident #6's hands that morning. Interview with a second MA on 05/11/21 at 6:11pm revealed: -Resident #6 needed staff assistance with toileting. -Resident #6 went to the bathroom independently and would pull the call light cord in the bathroom; staff then went down and helped him clean up after using the toilet. Interview with Resident #6's primary care provider (PCP) on 05/05/21 at 4:00pm revealed: -There was a hand washing issue for Resident #6 to have feces around and under his nails at meals. -The concern was for fecal contamination with residents sharing the bathroom and in the dining room area. Interview with the Resident Care Coordinator (RCC) on 05/05/21 at 8:41am revealed: -PCAs should have helped Resident #6 with toileting and personal hygiene, including hand-washing, after toileting. -Prior to 05/05/21, staff prioritized monitoring the cleanliness of the bathroom and hand hygiene was not addressed. -She had not instructed staff to specifically help Resident #6 with hand washing before meals. -Resident #6 having feces on and under his nails was a concern because the resident was spreading feces around the facility and risking the spread of infections like hepatitis.	D 269		

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D 269	Continued From page 8 Interview with the Administrator on 05/05/21 at 10:28am revealed: -There was a hand washing training done with all residents on 04/30/21. -It was not feasible to assist all residents with hand hygiene before meals; staff were expected to cue and remind residents to clean their hands. -Resident #6 was independent with toileting. -Staff were expected to increase monitoring for Resident #6 and check his bathroom and clothing for cleanliness. -PCAs were expected to help Resident #6 to wash his hands after toileting. -There was currently no system in place to ensure Resident #6 washed his hands prior to meals.	D 269		
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: FOLLOW-UP TO TYPE A2 VIOLATION The Type A2 Violation is abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to contact the primary care provider (PCP) for the acute and routine health care needs of 2 of 6 sampled residents (#4, #5) for multiple doses of unavailable	D 273		

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psychiatric medications (#4); and refusals of finger stick blood sugar (FSBS) checks and results greater than 500 mg/dl and refusals of insulin (#5).

The findings are:
1. Review of the current FL2 for Resident #4 dated 12/23/20 revealed:
-Diagnoses included coronary artery disease (CAD), congestive heart failure (CHF) and gastroesophageal reflux disease (GERD).
-There was a medication order for Latuda 40mg to be administered twice a day. (Latuda is used to treat schizophrenia.)

Review of the current Care Plan for Resident #4 dated 03/15/21 revealed he had a history of mental illness.

Review of Resident #4's eMAR for April 2021 revealed:
-There was a computer-generated entry for Latuda 40mg to be administered twice a day at 8:00am and 8:00pm.
-There was documentation that Latuda 40mg was not administered at 8:00am on 04/17/21, 04/20/21 and 04/22/21 with exception notes that indicated the medication was unavailable for administration at 8:00am on 04/17/21, 04/20/21 and 04/22/21.
-There was documentation that Latuda 40mg was not administered at 8:00pm on 04/14/21, 04/16/21, 04/19/21, 04/20/21 and 04/21/21 with exception notes that indicated the medication was unavailable for administration at 8:00pm on 04/14/21, 04/16/21, 04/19/21, 04/20/21 and 04/21/21.

Review of an Incident Report dated 04/05/21 revealed:

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-Resident #4 was observed to be arguing with another resident in the hallway.
-Resident #4 told staff, "I hit him in the eye".
-Supervision of Resident #4 was increased to every 30 minutes.

Interview with Resident #4 on 05/10/21 at 4:00pm revealed:
-He became angry with another resident and the MA "last week".
-He cussed at another resident and knocked cups off the medication cart when he believed the other resident had threatened him.

Telephone interview with the pharmacy technician for the facility's contracted pharmacy on 05/11/21 at 8:36am revealed:
-Sixteen doses of Latuda 40mg was dispensed on 02/10/21.
-Twenty-two doses of Latuda 40mg was dispensed on 04/22/21.
-She was unable to see where Latuda 40mg had been dispensed between 02/10/21 and 04/22/21.
-There was no clinical note to indicate why the Latuda had not been refilled between those dates.
-She was not able to see all multidose packs that were dispensed for Resident #4.

Interview with the account manager for the contracted pharmacy for the facility on 05/11/20 at 4:35pm revealed:
-The pharmacy received a signed medication order on 02/26/21 and the pharmacy system profiled it as a new order that was not recognized by the computer system at the pharmacy.
-The pharmacy received a physician's order for Latuda 40mg on 02/17/21 to start after the refills were completed from the previous order.
and the pharmacy computer system did not

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recognize the new order.
-Latuda was not filled until contacted by the facility on 04/22/21

Interview with the psychiatrist for Resident #4 on 05/10/21 at 9:40 am revealed:
-Resident #4 had a diagnosis of paranoid schizophrenia.
-Resident #4 was verbally aggressive towards him that morning.
-It was unusual for Resident #4 to curse at him.
-The facility had notified him 05/07/21 that Resident #4 had been verbally aggressive with another resident.
-Resident #4 had an increase in agitation due to a decrease in the psychotropic medication that was administered.
-He had decreased his medication because Resident #4 was having side effects from the psychotropic medication that was ordered.

Interview with the team leader for Resident #4's psychiatric provider on 05/11/21 at 9:40am revealed:
-The facility had not notified the provider of the missed doses of Latuda.
-The facility should have notified the provider Resident #4 had missed doses of the prescribed medication.
-The providers office would have provided samples of the medication if they had been made aware Resident #4 would miss doses.
-Missing doses of Latuda could cause Resident #4 to experience increased paranoia and agitation.

2. Review of Resident #5's current FL-2 dated 08/20/20 revealed diagnoses included diabetes mellitus and hypertension.

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Interview with the facility's contracted PCP on 05/05/21 at 4:00pm revealed:
-She did not know of frequent finger stick blood sugar (FSBS) check refusals for Resident #5.
-She was not concerned for one missed FSBS check but expected staff to notify her if there were 3 consecutive refusals.

a. Review of physician's orders dated 01/20/21 for Resident #5 revealed an order for finger stick blood sugar (FSBS) checks three times daily with Novolog SSI three times daily (Novolog is a fast acting insulin used to lower blood sugar).

Review of a physician's order form dated 03/03/21 for Resident #5 revealed:
-Resident #5 had poor glycemic control and snacks brought by family members needed to be sugar free.
-There was an order for FSBS greater than 500 to contact the PCP.

Review of Resident #5's April 2021 eMAR revealed:
-There was an entry for FSBS check once a morning, if the FSBS was greater than 500, call the PCP.
-The FSBS check with instructions for FSBS results greater than 500 was scheduled for 8:00am and separate from the Novolog SSI three times daily.
-There was an entry for FSBS checks three times daily with Novolog SSI.
-Staff documented FSBS results for 40 of 90 opportunities ranging from 127 to 572.
-There were 4 FSBS results greater than 500; on 04/18/21 at 7:00am the FSBS result was 551, on 04/17/21 at 7:00am the FSBS result was 545, on 04/29/21 at 7:00am the FSBS result was 572 and on 04/30/21 at 11:30am the FSBS result was 567.

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D 273	Continued From page 13 -Staff documented 50 of 90 FSBS checks were not done; 46 because Resident #5 refused, 3 because Resident #5's fingers were sore and 1 because Resident #5 was out of the facility. -There were 7 consecutive refusals at 7:00am, 11:30am and 5:00pm on 04/10/21 and 04/11/21 and 7:00am on 04/12/21. -Resident #5's FSBS result for 11:30am on 04/12/21 was 422. -There were 5 consecutive refusals at 11:30am and 5:00pm on 04/18/21 and 7:00am, 11:30am and 5:00pm on 04/19/21. -Resident #5's FSBS result for 7:00am on 04/20/21 was 454. -There were 3 consecutive refusals at 7:00am, 11:30am and 5:00pm on 04/22/21. -Resident #5's FSBS result for 7:00am on 04/23/21 was 545. -There were 3 consecutive refusals at 11:30am and 5:00pm on 04/27/21 and 7:00am on 04/28/21. -Resident #5's FSBS result for 11:30am on 04/28/21 was 500. -There was no documentation on the eMAR Resident #5's PCP was notified of consecutively refused FSBS checks and FSBS results greater than 500. Review of Resident #5's May 2021 eMAR revealed: -There was an entry for FSBS check once a morning, if the FSBS was greater than 500, call the PCP. -The FSBS check with instructions for FSBS results greater than 500 was scheduled for 8:00am and separate from the Novolog SSI three times daily. -There was an entry for FSBS checks three times daily with Novolog SSI. -Staff documented 4 FSBS results ranging from	D 273		

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359 to 493; there were no results documented for 7:00am and 11:30am on 05/01/21 through 05/05/21.
-Staff documented Resident #5's fingers were sore on 05/01/21 at 7:00am and 05/03/21 at 7:00am; the resident was not in the building on 05/05/21 at 11:30am; and the refused 7 FSBS checks.

Review of the pharmacist consultation report dated 04/06/21 for Resident #5 revealed:
-The pharmacist noted Resident #5 had been refusing FSBS checks per documentation on the electronic medication administration record (eMAR).
-The pharmacist recommended additional documentation which included notification to the prescriber.

Review of electronic care notes for Resident #5 revealed:
-The entry dates were cut off on the copy of requested notes for April 2021 through May 2021.
-There was documentation staff notified the facility's contracted primary care provider (PCP) on 04/18/21 at 8:30pm that Resident #5 refused 5:00pm medications including the FSBS check.
-There was documentation staff notified the PCP from the Veteran's Administration on 04/27/21 at 8:00pm that Resident #5 refused 5:00pm and bedtime medications including the FSBS check.

Review of Resident #5's April and May 2021 eMARs, electronic care notes dated 04/01/21 through 05/04/21 and PCP notification forms revealed there was no documentation Resident #5's PCP was notified of 4 FSBS results greater than 500, 4 instances of 3 or more consecutive FSBS check refusals as well as refusal of multiple FSBS checks.

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D 273	Continued From page 15 Interview with Resident #5 on 05/11/21 at 5:54pm revealed: -He did not know who his PCP was. -He did not always refuse medications and FSBS checks, sometimes staff did not come to his room. -He like to walk to the store, eat lunch outside the facility and sit outside. Interview with a medication aide (MA) on 05/11/21 at 7:24am revealed: -Her initials were on Resident #5's eMAR for 7:00am FSBS check refusals on 04/10/21, 04/21/21 and 04/28/21. -She would attempt 3 times to check Resident #5's FSBS before documenting he refused. -She also reported to the oncoming MA for first shift to try checking Resident #5's FSBS before breakfast. -She reported all FSBS check refusals to the first shift lead Supervisor/MA. -The lead Supervisor/MA contacted Resident #5's PCP. -She did not document reporting the FSBS check refusals to the lead Supervisor/MA. Interview with a second MA on 05/10/21 at 2:30pm revealed: -MAs were supposed to fax the PCP for FSBS checks that were refused each time. -The MA was supposed to document the FSBS check was refused and the contact with the PCP in a template in the computer system. Interview with a third MA on 05/11/21 at 6:11pm revealed: -She documented administration and refusals for Resident #5's evening medications. -She faxed the facility's contracted PCP after	D 273		

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Resident #5 had three consecutive refusals.
-Faxed notifications were kept in the medication room behind the front desk.
-She did not know where faxes that had been sent to the PCP were kept because they were taken out of the folder in the medication room once it was faxed.
-She did not know if the faxed forms had been scanned into an electronic record.

Interview with the lead Supervisor/MA on 05/11/21 at 6:59pm revealed:
-For FSBS results greater than 500 like the 551 on 03/03/21, 546 on 03/05/21 and 567 on 04/30/21, the MA was supposed to contact the PCP.
-She "probably" sent a text message notifying the PCP of FSBSs greater than 500.
-It was hard to contact a provider at the Veteran's Administration for Resident #5.
-Staff had not reported Resident #5's FSBS check and/or medication refusals to her.

Telephone interview with the facility's contracted PCP on 05/11/21 at 5:01pm revealed:
-Resident #5 had poorly controlled diabetes mellitus and was at increased risk of damage to his eyes, kidneys, heart and feet by not having his FSBS monitored and treated.
-She was not notified of the number of FSBS check refusals, the consecutive FSBS check refusals and the 7 FSBS results greater than 500.
-Staff may have notified Resident #5's Veteran's Administration provider.

Attempted telephone interviews with Resident #5's Veteran's Administration Provider on 05/11/21 at 1:58pm and 05/11/21 at 4:58pm were unsuccessful.

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b. Review of physician's orders dated 01/20/21 for Resident #5 revealed an order for Levemir insulin 42 units subcutaneously (SQ) at bedtime (Levemir is a long acting insulin used to regulate blood sugar levels).

Review of a physician's order form dated 04/02/21 for Resident #5 revealed:
-There was a strike through on the preprinted order for Levemir 42 units SQ at bedtime.
-There was a handwritten entry for Lantus written above the strike through documenting Resident #5 was on Lantus 42 units SQ at bedtime (Lantus is a long acting insulin used to regulate blood sugar levels).
-The form was signed by the physician listed on prescription labels from the Veteran's Administration.

Review of a physician's visit form dated 04/02/21 for Resident #5 revealed:
-There was an order to increase Lantus to 50 units at bedtime.
-The form was signed by the physician listed on prescription labels from the Veteran's Administration.

Review of Resident #5's April 2021 electronic medication administration record (eMAR) revealed:
-There were two entries for Lantus 50 units SQ daily at bedtime scheduled at 8:00pm.
-There was documentation Resident #5 refused Lantus on 04/17/21, 04/18/21, 04/23/21 and 04/27/21; there was no documentation the resident's PCP was notified.
-There was an entry for FSBS checks three times daily.
-Resident #5's FSBS result on 04/18/21 at 7:00am was 551; there were no results

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documented at 11:30am and 310 at 5:00pm on 04/18/21.
-Resident #5's FSBS result on 04/24/21 at 7:00am was 500; there were no results documented at 11:30am and 310 at 5:00pm on 04/24/21.

Review of Resident #5's May 2021 eMAR revealed:
-There was an entry for Lantus 50 units SQ daily at bedtime scheduled at 8:00pm.
-Staff documented Resident #5 refused the Lantus on 05/01/21; there was no documentation the resident's PCP was notified.
-There was an entry for FSBS checks three times daily.
-There were no FSBS results documented at 7:00am and 11:30am on 05/01/21; the 5:00pm FSBS result was 359 on 05/02/21.

Review of electronic care notes for Resident #5 revealed:
-The entry dates were cut off on the copy of requested notes for March 2021 through May 2021.
-There was documentation staff notified the facility's contracted primary care provider (PCP) on 04/18/21 at 8:30pm that Resident #5 refused bedtime medications including insulin.
-There was documentation staff notified the PCP from the Veteran's Administration on 04/27/21 at 8:00pm that Resident #5 refused bedtime medications including insulin.

Review of Resident #5's March, April and May 2021 eMARs, electronic care notes dated 03/01/21 through 05/04/21 and PCP notification forms revealed there was no documentation Resident #5's PCP was notified Resident #5 refused long acting insulin on 03/13/21, 03/23/21,

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D 273	Continued From page 19 04/17/21, 04/23/21 and 05/01/21. Interview with a medication aide (MA) on 05/10/21 at 2:30pm revealed: -MAs were supposed to fax the PCP for medications that were refused or not available for administration each time. -The MA was supposed to document the medication was refused or not available and the contact with the PCP in a template in the computer system. Interview with a second MA on 05/11/21 at 6:11pm revealed: -She documented administration and refusals for Resident #5's evening medications. -She faxed the facility's contracted PCP after Resident #5 had three consecutive refusals. -Faxed notifications were kept in the medication room behind the front desk. -She did not know where faxes that had been sent to the PCP were kept because they were taken out of the folder in the medication room once it was faxed. -She did not know if the faxed forms had been scanned into an electronic record. Interview with the lead Supervisor/MA on 05/11/21 at 6:59pm revealed: -It was hard to contact a provider at the Veteran's Administration for Resident #5. -Resident #5's PCP was the facility's contracted PCP. -Staff had not reported Resident #5's FSBS check and/or medication refusals to her. Telephone interview with the facility's contracted PCP on 05/11/21 at 5:01pm revealed: -She did not know of Resident #5 refusing his long acting insulin on 03/13/21, 03/23/21,	D 273		

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D 273	Continued From page 20 04/17/21, 04/23/21 and 05/01/21. -Staff may have notified Resident #5's Veteran's Administration provider. Attempted interview on 05/11/21 at 3:35pm with the medication aide (MA) who documented Resident #5's refusals of long acting insulin on 03/23/21, 04/17/21, 04/23/21 and 05/01/21 was unsuccessful. Interview with the Administrator on 05/07/21 at 3:00pm revealed: -She was not aware of Resident #5's refusals of multiple medication including insulin and FSBS checks refusals. -She was not aware Resident #5's PCP was not notified. Second interview with the Administrator on 05/11/21 at 7:47pm revealed: -She expected the MA on duty to notify the PCP immediately for medications that were not available for administration. -She expected the MA on duty to notify the resident's PCP after the third consecutive refusal of a dose of the same medication. -The MA was expected to document medications not given and the reason on the eMAR and document notifying the PCP in the electronic care notes. Attempted telephone interview with Resident #5's family member on 05/11/21 at 8:54am was unsuccessful. Attempted interview with Resident #5's Veteran's Administration Provider on 05/11/21 at 1:58pm and 05/11/21 at 4:58pm were unsuccessful. The facility failed to contact the primary care	D 273		

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D 273	Continued From page 21 provider (PCP) for the acute and routine health care needs of 2 of 6 sampled residents related to refusals of insulin and blood sugar monitoring and notifying the PCP when fingerstick blood sugar was greater than 500 mg/dl (#5) and contacting the PCP for inability to obtain a psychotropic medication used to treat paranoid schizophrenia (#4). The facility's failure resulted in Resident #4 experiencing increased aggressive behavior towards another resident and Resident #5 having finger stick blood sugars greater than 500 mg/dl which 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 05/10/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 25, 2021.	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.	D 276		

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This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 5 sampled residents (#7) who had an order for oxygen as needed had a portable oxygen tank available to take with them when out of the facility.

The findings are:

Review of Resident #7's current FL-2 dated 04/14/21 revealed:
-Diagnoses included chronic obstructive pulmonary disease, arthritis and osteoporosis.
-There was an order for oxygen at 2 liters per minute; the order did not specify as needed (PRN) or continuous.

Review of a physician's order clarification request dated 04/29/21 for Resident #7 revealed an order for oxygen 2 liters per minute via nasal canula as needed.

Review of Resident #7's current care plan dated 04/23/20 revealed the resident used oxygen at 2 liters per minute and had shortness of breath.

Review of Resident #7's Licensed Health Professional Support (LHPS) evaluation dated 02/25/21 revealed:
-Resident #7 had an LHPS task of oxygen administration and monitoring.
-There was documentation staff monitored Resident #7's oxygen which was set on 3 liters

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per minute via nasal canula.

Review of Resident #7's May 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for oxygen at 2 liters per minute as needed with a start date of 05/06/21.
-There was an entry to check oxygen tanks every shift with a start date of 05/06/21.
-There were no staff initials documented for either entry.

Observation on 05/04/21 at 10:43am revealed Resident #7 was sitting in a chair in her room wearing oxygen via nasal canula attached to an oxygen concentrator set at 2 liters per minute with difficulty breathing.

Interview with Resident #7 on 05/04/21 at 10:43am revealed her oxygen was working fine and she did not have any concerns.

Observation on 05/06/21 at 12:04pm revealed:
-Resident #7 was walking through the front door of the facility.
-Resident #7 did not have an oxygen tank with her.
-Resident #7 was panting and short of breath.
-Resident #7's family member told all staff present, "I have asked three times for her (Resident #7) portable oxygen tank. They said they would teach her (Resident #7), but they have not."

Interview with Resident #7's family member on 05/06/21 at 12:04pm revealed:
-She asked for the portable oxygen tank to be given to her so she could learn how to use it but staff had not given it to her.
-Resident #7 came back panting, she always did

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when returning from a medical appointment.
-She took Resident #7 to her appointment every month.
-She had asked staff for the last three months for Resident #7's portable oxygen tank to be provided and never received it.
-She would have liked to take Resident #7 to lunch but the resident needed her oxygen.
-Resident #7 needed a haircut but the family could not take her because she did not have a portable oxygen tank for the resident.
-Resident #7 had been using oxygen for more than six months.
-Initially Resident #7 did not use the oxygen all the time but she had declined and was using the oxygen all the time.
-Resident #7 would not complain and did not like to ask for things.

Observation on 05/06/21 at 12:26pm revealed Resident #7 was sitting in a chair in her room wearing oxygen via nasal canula attached to an oxygen concentrator set at 2 liters per minute and short of breath.

Interview with Resident #7 on 05/06/21 at 12:26pm revealed:
-She was breathing easier with her oxygen back on.
-She had gone to a medical appointment with her family member without the oxygen.
-She had not eaten lunch and did not want anything to eat.
-She only went outside at the end of the hall to smoke a cigarette and returned right back to her room.
-She did not think any of the staff knew she had a portable oxygen tank.
-She had the portable oxygen tank for a year.

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D 276	Continued From page 25 Interview with a medication aide (MA) on 05/06/21 at 12:28pm revealed: -She did not know Resident #7 should have taken a portable oxygen tank with her when she left the facility. -The last time Resident #7 left the facility for a medical appointment she left without the portable oxygen tank. -She saw Resident #7 walking around the facility without her oxygen. -She did not know Resident #7 had a portable oxygen tank until 05/06/21. -She did not know what the order was for Resident #7's oxygen. -She did not know Resident #7's family member had asked for the portable oxygen tank when the resident left the facility. -Staff stored portable tanks for residents on oxygen in the storage room by the dining room. -There was a list of residents who had portable tanks and Resident #7 was not on the list. -She was not sure who was responsible for making the list of residents using oxygen and making sure they enough oxygen. -She checked Resident #7's eMAR and did not see an order for continuous oxygen. Interview with a second MA on 05/10/21 at 2:30pm revealed: -She walked Resident #7 out to her family member's car for medical appointments. -The family member had never asked for Resident #7's portable oxygen until last week (05/06/21). -She did not have any conversation with Resident #7's family member on 05/06/21 when the resident was picked up for her appointment. -MAs checked residents' portable oxygen tanks daily. -She did not know Resident #7 had a portable	D 276		

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oxygen tank; she thought the resident just used an oxygen concentrator.
-MAs did not know if oxygen had to be sent with Resident #7 when she left the facility.

Interview with the lead Supervisor/MA on 05/06/21 at 1:12pm revealed Resident #7's family member did not ask her about a portable oxygen tank before 05/06/21.

Interview with the Divisional Director of Clinical Services (DDCS) 05/06/21 at 3:12pm revealed:
-Resident #7 should have had oxygen on.
-The MAs on duty were new to the facility and still training.
-Resident #7 was not in distress when she returned to the facility on 05/06/21.
-Resident #7 walked around the facility without oxygen; the resident used oxygen PRN.

Telephone interview with Resident #7's family member on 05/07/21 at 10:45am revealed:
-Resident #7 was originally ordered supplemental oxygen in the fall of 2019 for use as needed.
-She did not know if the order for oxygen was ever changed to continuous.
-Resident #7 felt she needed the oxygen more than occasionally.
-Resident #7 currently always needed oxygen; the resident wore oxygen at all times when she was in her room.
-She did not remember the name of the staff she asked for the portable oxygen.
-Resident #7's primary care provider (PCP) was upset that Resident #7 did not have her oxygen with her for use at the time of her last three appointments.
-She did not know if the PCP had contacted the staff about making sure Resident #7 left the facility with her portable oxygen tank.

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-Staff should have helped with the portable oxygen tank before Resident #7 left the facility if she needed help.

Interview with a personal care aide (PCA) on 05/07/21 at 4:17pm revealed:
-Resident #7 used her oxygen most of the time.
-Resident #7 would go outside and smoke a cigarette and go right back to her room.
-Resident #7 did not go to the dining room for dinner.
-She had never seen Resident #7 sit through a meal without using her oxygen.
-Resident #7 never complained about anything and did not ask for help with anything.

Telephone interview with a representative of the medical supply company on 05/07/21 at 11:08am revealed:
-A portable tank was provided when Resident #7's oxygen was set up in 2019.
-There had been no additional portable oxygen tanks delivered.

Observation of Resident #7's portable oxygen supply on 05/07/21 at 4:21pm revealed:
-There was an oxygen concentrator in Resident #7's room.
-There was a small oxygen cylinder (approximately 18 inches in length) inside a cloth case with a shoulder strap.
-The small cylinder had an access meter attached showing the tank was empty.
-There was nasal canula tubing attached to the access meter and the knob was set on 1 L instead of the off position.
-There was a sticker on the top of the oxygen canister with a lot number and indicating it held 170 liters.
-There were no dates on the oxygen cylinder.

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D 276	Continued From page 28 Interview with Resident #7 on 05/07/21 at 4:22pm revealed: -The portable oxygen had been in her room since the medical supply company delivered it over a year ago. -She had never used the portable oxygen tank. Interview with the LHPS Nurse on 05/11/21 at 12:30pm revealed: -Resident #7 had dyspnea and difficulty breathing with exertion or activity. -Resident #7 should have taken a portable oxygen tank with her when she left the facility. -The MA should have checked the portable oxygen tank and made sure Resident #7's family member knew how to use it before Resident #7 left the facility for her appointment. -Resident #7 could have gone into respiratory distress leaving the facility without oxygen and then needing it while she was out. Interview with the lead Supervisor/MA on 05/11/21 at 6:50pm revealed: -Staff should have given Resident #7 her portable oxygen before she left for her medical appointment. -Staff should have checked Resident #7's portable oxygen tank and made sure there was oxygen in the tank before the resident left. -She did not know the portable tank was empty on 05/06/21. Interview with the Administrator on 05/07/21 at 3:00pm revealed: -She was not aware Resident #7's family had made requests for portable oxygen tanks when the resident left the building. -She did not know the specifics of Resident #7's oxygen orders.	D 276		

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D 276	Continued From page 29 -Residents should have what they needed, such as portable oxygen, when leaving the facility for appointments. Attempted interviews with Resident #7's PCP on 05/06/21 at 4:02pm and 05/10/21 at 10:25am were unsuccessful. The facility failed to ensure Resident #7 had a full portable oxygen tank while out of the facility resulting in the resident experiencing increased shortness of breath. This failure was detrimental to the health 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 05/25/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 25, 2021.	D 276		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure foods being stored, prepared, and served to residents were	D 282		

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D 282	Continued From page 30 protected from contamination. 1.Observation of the facility's ice machine on 05/05/21 at 8:17am and 8:40am revealed: -It was approximately 75% full of cubed ice. -On the upper front inside side wall of the ice machine there was a plastic ice chute cover attached to the front wall of the ice machine that had pink, yellow and black substances on the top and sides of the plastic ice chute cover. -There was a brown substance along the top inner side of the ice machine. -On the upper inside front wall of the ice machine there was a pink and brown substance covering both ends of the ice machine. -There was condensation along the front inner upper wall, where the pink, yellow and black substances were located. -Water from the condensation was dripping down the inner front side and the top of the ice machine where the ice machine door opened, on the ice in the ice bin. -On both sides of the opening of the ice machine's ice dispensing slot there were pink and black substances. Review of the dietary's cleaning assignments not dated revealed no instructions on when the facility's ice machine was to be cleaned and by whom. Interview with a cook on 05/05/21 at 11:08am revealed: -She had worked in the kitchen at the facility since 2017. -No one checked behind the kitchen staff to make sure the cleaning was done. -She last cleaned the ice machine a month ago. -The kitchen staff was responsible for cleaning the ice machine weekly.	D 282		

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D 282	Continued From page 31 -The staff removed all the ice out of the ice machine and cleaned the sides, the bottom and rinsed the machine with water. -She had never been trained on how to clean the ice machine. -Residents were last served ice from the facility's ice machine yesterday (05/04/21) for dinner. Interview with a dietary aide on 05/05/21 at 11:55am revealed: -She had worked at the facility for a week. -She had not been trained how to clean the facility's ice machine. -She last served the residents ice from the facility's ice machine yesterday (05/04/21) at lunch. Interview with the Dietary Manager (DM) on 05/05/21 at 8:20am revealed: -He was hired as the DM 3 weeks ago. -The residents had last been given ice from the ice machine on 05/05/21 for breakfast. -The facility's ice machine was last cleaned on 04/28/21. -The kitchen staff was responsible for cleaning the ice machine weekly. -Staff must have only cleaned the outside of the ice machine on 04/28/21 and missed the inside of the ice machine. Interview with the Administrator on 05/05/21 at 8:30am revealed: -She and the previous DM were trained by the Regional Director of Maintenance on how to clean the facility's ice machine before the current DM being hired (date unknown). -The current DM had not been trained on cleaning the ice machine. -The kitchen staff were responsible for cleaning the ice machine monthly.	D 282		

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D 282	Continued From page 32 Second interview with the Administrator on 05/05/21 at 10:28am revealed: -There was no staff to supervise the cleaning of the ice machine because the current DM had not been trained on how to clean the ice machine and did not know the process. -She was concerned about the pink, yellow and black substances inside the facility's ice machine and did not know what it was. -She did not know the pink, yellow and black substances was inside the facility's ice machine Interview with the Administrator on 05/06/21 at 10:57am revealed there was no documentation of the facility's ice machine being cleaned since February 2021 when it was repaired. Refer to second interview with the Administrator on 05/05/21 at 10:28am 2.Observation of the walk-in refrigerator on 05/05/21 at 7:53am revealed: -There was a build-up of a black substance on the exterior of the entry door and interior of the door of the walk-in refrigerator covering more than half the surface of the door including the rubber trim around the door. -There was a build-up of a black substance on all four walls of the walk-in refrigerator that sporadically covered the walls from the floor to the ceiling. -The floor of the walk-in freezer had several dark brown, black stained areas in the corner under the metal shelves. Interview with a cook on 05/05/21 at 11:08am revealed: -She had worked in the kitchen at the facility since 2017.	D 282		

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D 282	Continued From page 33 -The black substance on the door, walls and floor of the walk-in refrigerator had been there for about a month. -Cleaning the walk-in refrigerator consisted of taking everything off the shelves and moping the floors, sweeping the floors and trying to wipe the wall down the "best that she could". -The black substance in the walk-in refrigerator had been there since she started working and she would wipe the walls down with Clorox water and it would just come back. -The black substance on the walk-in refrigerator could get in the food. -The kitchen staff was responsible for clean the walk-in refrigerator weekly. -She had last cleaned he walk-in refrigerator about a month ago. -Staff did not have time to clean because of being short staffed in the kitchen. -She had not told the Administrator about the black substance in the walk-in refrigerator. -The Administrator did a walk-through of the kitchen to see if it was clean yesterday (05/04/21). Interview with the Dietary Manager (DM) on 05/05/21 at 8:20am revealed the black substance on the outside, inside and around the trim of the door of the walk-in refrigerator and on the walls and floor of the walk-in refrigerator was black substance. Interview with the Administrator on 05/05/21 at 8:30am revealed: -She did not know about the black substance build up on the door, walls and floor of the walk-in refrigerator. -She did not know the last time the walk-in refrigerator had been cleaned. -The kitchen staff were responsible for cleaning	D 282		

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the walk-in refrigerator monthly.
-She planned to have the walk-in refrigerator deep cleaned when the new kitchen supplies arrived.

Second interview with the Administrator on 05/05/21 at 10:28am revealed:
-She did not know how long the black substance had been in the walk-in refrigerator.
-She had last seen the walk-in refrigerator about 2 weeks ago and it was not "that bad".
-The black substance was on the door and walls of the walk-in refrigerator 2 weeks ago but not on the floors.
-She expected the kitchen staff to notify her of the black substance in walk-in refrigerator.

Refer to second interview with the Administrator on 05/05/21 at 10:28am

3. Observation of the walk-in refrigerator on 05/05/21 at 7:53am revealed:
-There were four sets of metal shelves that lined the walls of the walk-in refrigerator.
-There was a dried white residue and a black build-up on the shelves in the walk-in refrigerator.
-There was a thick layer of brown dust build-up on the metal shelves.
-All the metal shelves from the second row of shelving down held packaged food and beverages.

Interview with the Administrator on 05/05/21 at 8:30am revealed:
-The kitchen staff was responsible for cleaning the shelves in the walk-in refrigerator (frequency unknown).
-She did not know the last time the shelves in the walk-in refrigerator had been cleaned.
-She planned to have the walk-in refrigerator

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D 282	Continued From page 35 deep cleaned when the new shelves arrived (date unknown). Second interview with the Administrator on 05/05/21 at 10:28am reveled: -She knew the shelves in the walk-in refrigerator were rusted and increased the risk for food contamination. -The DM was responsible for checking behind the kitchen staff to make sure the cleaning was completed. Refer to second interview with the Administrator on 05/05/21 at 10:28am _____ Second interview with the Administrator on 05/05/21 at 10:28am reveled the DM is responsible for reviewing the kitchen cleaning check list (frequency unknown).	D 282		
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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Based on interviews and record reviews, the facility failed to ensure contact with the prescribing physician for clarification of medication orders for 1 of 5 sampled residents (Resident #5) regarding multiple insulins that were ordered.

The findings are:

Review of Resident #5's current FL-2 dated 08/20/20 revealed:
-Diagnoses included diabetes mellitus and hypertension.
-A medication order for Levemir 42 unit subcutaneously daily at bedtime. (Levemir is a long acting insulin used to regulate blood sugar levels.)

Review of physician's orders dated 01/20/21 for Resident #5 revealed an order for Levemir 42 units at bedtime.

Review of a physician's order form dated 04/02/21 for Resident #5 revealed:
-There was a strike through on the preprinted order for Levemir 42 units subcutaneously at bedtime.
-There was a handwritten entry for Lantus written above the strike through (Lantus is a long acting insulin used to regulate blood sugar levels.).
-The form was signed by a physician from the Veteran's Administration.

Review of a physician's visit form dated 04/02/21 for Resident #5 revealed:
-There was an order to increase Lantus to 50 units at bedtime.
-There was no documentation to discontinue Levemir 42 units for Resident #5 or previous order for Lantus administration.

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D 344	Continued From page 37 -The form was signed by a physician from the Veteran's Administration. Review of Resident #5's April 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Levemir 42 units at bedtime scheduled for 8:00pm. -There was documentation Levemir 42 units was administered 04/01/21 through 04/13/21 and 04/15/21, 04/29/21 and 04/30/21. -There was documentation Levemir 42 units was not administered on 04/14/21 because there was a new order for Lantus 50 units. -There was an entry for Lantus 50 units daily at bedtime scheduled at 8:00pm with a start date of 04/13/21 and a discontinue date of 04/14/21. -There was documentation one dose was administered on 04/13/21. -There was a second entry for Lantus 50 units at bedtime scheduled at 8:00pm with a start date of 04/13/21. -There was documentation Lantus 50 units was administered 04/14/21 through 04/16/21, 04/19/21 through 04/22/21, 04/24/21 through 04/26/21, 04/28/21 and 04/29/21. -Staff documented administering both Levemir 42 units and Lantus 50 units on 04/13/21, 04/15/21, 04/16/21, and 04/29/21. Review of Resident #5's May 2021 eMAR revealed: -There was an entry for Levemir 42 units at bedtime scheduled for 8:00pm. -There was no documentation Levemir was administered on 05/01/21. -There was documentation Levemir 42 units was administered on 05/02/21. -There was documentation Levemir was not administered on 05/03/21 and 05/04/21 because	D 344		

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the medication order had changed.
-There was an entry for Lantus 50 units daily at bedtime scheduled at 8:00pm.
-There was documentation Resident #5 refused Lantus on 05/01/21.
-There was documentation Lantus 50 units was administered 05/02/21 through 05/04/21.
-Staff documented administering both Levemir 42 units and Lantus 50 units on 05/02/21.

Review of the Resident #5's physicians' orders and eMARs revealed it was unclear whether Levemir or Lantus should be administered to Resident #5.

Interview with a MA on 05/11/21 at 6:11pm revealed:
-She worked second shift and administered Lantus to Resident #5.
-Resident #5 was on Levemir but the order was changed to Lantus 50 units (date not specified); she documented the order change on the eMAR in comments for not administering Lantus.
-It was indicated on Resident #5's bottle of Lantus that Lantus was equivalent to Levemir.

Interview with the lead Supervisor/ MA on 05/11/21 at 6:59pm revealed:
-She did not know why Lantus and Levemir were both on Resident #5's eMAR.
-Resident #5 was currently on Lantus and the Levemir had been discontinued (date not specified).

Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/10/21 at 6:59pm revealed:
-There was no current medication order for Levemir in Resident #5's profile.
-On 04/13/21, the pharmacy received an order

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D 344	Continued From page 39 dated 04/02/21 to discontinue Levemir and change to Lantus. -Levemir was removed from Resident #5's profile on 04/13/21 and Lantus was added the same day. -She did not know why Levemir was showing up on Resident #5's current eMAR; the order was inactive on the pharmacy side of the eMAR system. Telephone interview with the facility's contracted primary care provider (PCP) on 05/11/21 at 5:01pm revealed: -Resident #5 was not on Levemir because his insurance did not cover it; Resident #5 was on Lantus and should not have received both. -She had referred him to an endocrinologist who may have written the medication order for Lantus dated 04/02/21. Attempted telephone interviews with Resident #5's Veteran's Administration Provider on 05/11/21 at 1:58pm and 05/11/21 at 4:58pm were unsuccessful.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	D 358		

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D 358	Continued From page 40 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 residents sampled (#4 and #5) including insulin, oral anti-diabetic and anti-reflux medications (#5) and a medication used to prevent side effects of psychotropic medication (#4). The findings are: Review of the facility's undated Medication Management policy revealed: -Physician/prescriber orders were required for all medications and treatments. -The community should forward updated physician order information daily (to the pharmacy). -Any request to change an existing order should be treated by the Community as a new order. -The medication order were to be sent to the facility pharmacy via fax. -For new or changed physician orders the Wellness Director or one of the community's licensed nurses should enter the new order on the medication administration record (MAR) and discontinue the previous order in the medication record and enter the new medication order. -The Community staff should review all on-demand medications daily and reorder when a 5-day supply of medications is remaining. -To reorder medication, the Community staff should peel off the 2 part label from the medication package and place the label on the pharmacy's refill/reorder form or write the medication to be refilled on the medication reorder form and fax the record to the pharmacy. -The Community staff should review the transmitted reorder for status and potential issues and pharmacy response.	D 358		

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D 358	Continued From page 41 -The software will indicate whether the reorder is confirmed, pharmacy follow up is required or an invalid prescription number has been entered. 1. Review of the current FL2 for Resident #4 dated 12/23/20 revealed: -Diagnoses included coronary artery disease (CAD), congestive heart failure (CHF) and gastroesophageal reflux disease (GERD). -There was a medication order for Latuda 40mg to be administered twice a day. (Latuda is a medication used to treat schizophrenia.) Review of the Resident Register for Resident #4 dated 08/16/18 revealed Division of Social Services (DSS) was his guardian. Review of the current Care Plan for Resident #4 dated 03/15/21 revealed he had a history of mental illness that was not specified. Review of Resident #4's electronic medication administration record (eMAR) for April 2021 revealed: -There was a computer-generated entry for Latuda 40mg to be administered twice a day at 8:00am and 8:00pm. -There was documentation Latuda 40mg was not administered at 8:00am on 04/17/21, 04/20/21 and 04/22/21 with exception notes that indicated the medication was unavailable for administration. -There was documentation Latuda 40mg was not administered at 8:00pm on 04/14/21, 04/16/21, 04/19/21, 04/20/21 and 04/21/21 with exception notes that indicated the medication was unavailable for administration. Interview with the pharmacy technician for the facility's contracted pharmacy on 05/11/21 at	D 358		

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D 358	Continued From page 42 8:36am revealed: -Sixteen doses of Latuda 40mg were dispensed on 02/10/21. -Twenty-two doses of Latuda 40mg were dispensed on 04/22/21. -She was unable to see where Latuda 40mg had been dispensed between 02/10/21 and 04/22/21. -There was no clinical note to indicate why the Latuda had not been refilled between those dates. -She was not able to see all multidose packs that were dispensed for Resident #4. Interview with the account manager for the contracted pharmacy for the facility on 05/11/20 at 4:35pm revealed: -The pharmacy received a physician's order for Latuda 40mg on 02/17/21 to start after the refills were completed from the previous order. -The last refill for the previous order was dispensed on 03/28/21. -The pharmacy computer system did not recognize the new order and the Latuda was not filled until contacted by the facility on 04/22/21. Interview with the team leader for Resident #4's psychiatric provider on 05/11/21 at 9:40am revealed: -The facility had not notified the provider of the missed doses of Latuda. -The facility should have notified the provider that Resident #4 was missing doses of the Latuda. -The providers office would have provided samples of the medication if they had been made aware Resident #4 would miss doses. -Missing doses of Latuda could cause Resident #4 to experience increased paranoia and agitation. Interview with the psychiatrist for Resident #4 on	D 358		

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D 358	Continued From page 43 05/10/21 at 9:40 am revealed: -Resident #4 had a diagnosis of paranoid schizophrenia. -Resident #4 was verbally aggressive towards him that morning. -It was unusual for Resident #4 to curse at him. -The facility had notified him 05/07/21 that Resident #4 had been verbally aggressive with another resident. Interview with Resident #4 on 05/10/21 at 4:00pm revealed: -He continued to be angry with his psychiatrist regarding their interaction that morning. -He cursed at his psychiatrist that morning because the psychiatrist had accused him of not taking his medications. Refer to interview with a medication aide (MA) on 05/10/21 at 2:30pm. Refer to interview with a second MA on 05/11/21 at 6:11pm. Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on 05/10/21 at 6:59pm. Refer to interview with the Administrator on 05/11/21 at 7:48pm. 2. Review of Resident #5's current FL-2 dated 08/20/20 revealed diagnoses included diabetes mellitus and hypertension. Observations of medications on hand for Resident #5 on 05/07/21 at 3:49pm revealed all of Resident #5's medications were in prescription bottles dispensed from the Veteran's Administration kept in a plastic storage bag on the medication cart.	D 358		

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D 358	Continued From page 44 Interview with a medication aide (MA) on 05/10/21 at 2:30pm revealed: -Resident #5 received his medications from the Veteran's Administration pharmacy. -If there were problems with Resident #5's medications or orders, the MAs called the number on the resident's prescription bottles. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/10/21 at 6:59pm revealed: -Pharmacy staff usually only added orders for Resident #5's profile and did not dispense medications for the resident. -Resident #5's medications were dispensed from the Veteran's Administration pharmacy. a. Review of physician's orders dated 01/20/21 for Resident #5 revealed an order to check FSBS three times daily with Novolog sliding scale insulin (SSI) subcutaneously (SQ) as follows: for FSBS 150-200 give 2 units, FSBS 201-250 give 4 units, FSBS 251-300 give 6 units, FSBS 302-350 give 8 units, FSBS 351-400 give 10 units, FSBS 401-500 give 12 units; hold for FSBS less than 150 (Novolog is a fast acting insulin used to lower blood sugar levels). Review of a physician's order form dated 03/03/21 for Resident #5 revealed: -Resident #5 had poor glycemic control and snacks brought by family members needed to be sugar free. -There was an order for FSBS greater than 500 to give 12 units of Novolog and contact the PCP. Review of Resident #5's May 2021 electronic medication administration record (eMAR) revealed:	D 358		

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D 358	Continued From page 45 -There was an entry to check FSBS three times daily at 7:00am, 11:30am and 5:00pm with Novolog SSI as follows: for FSBS 150-200 give 2 units, FSBS 201-250 give 4 units, FSBS 251-300 give 6 units, FSBS 302-350 give 8 units, FSBS 351-400 give 10 units, FSBS 401-500 give 12 units; hold for FSBS less than 150. -There were no FSBS results documented for 7:00am and 11:30am on 05/01/21 through 05/05/21. -Staff documented 6 FSBS results at 5:00pm 05/01/21 through 05/06/21 ranging from 359 to 500; and 1 FSBS result at 11:30am on 05/06/21 of 594. -Staff documented Resident #5's fingers were sore on 05/01/21 at 7:00am and 05/03/21 at 7:00am; the resident was not in the building on 05/05/21 at 11:30am; and the resident refused 8 FSBS checks. Observations on 05/05/21 from 8:00am to 8:15am revealed: -At 8:00am the MA reviewed the medications due on the computer screen. -The MA announced Resident #5's 7:00am FSBS check was marked with alert that it had not been done. -The MA announced, "apparently she (prior shift MA) did not know about it (FSBS check) or he refused because it was not done." -At 8:15am Resident #5 was leaving the dining room after the breakfast meal. Interview with Resident #5 on 05/05/21 at 8:15am revealed: -He had not had his FSBS checked yet that morning (05/05/21). -He had not gone to the medication cart for his morning medications yet. -He had just finished eating breakfast.	D 358		

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D 358	Continued From page 46 Observation on 05/05/21 at 8:27am revealed: -Resident #5 was standing at the medication cart and told the MA, "I did not refuse. I did not see her (prior shift MA) that morning (05/05/21). She did not come in my room." -The MA turned away from Resident #5 and continued to report the third shift MA reported the resident refused. -Resident #5 told the MA who was still turned away, "I did not refuse. I told you I did not see her that morning." -The MA did not acknowledge what Resident #5 said. Interview with the MA on 05/05/21 at 8:27am revealed: -She would have to fax the PCP that Resident #5 refused his 7:00am FSBS check and document a note in the electronic care notes. -The third shift MA was usually good about documenting FSBS checks and refusals. -She did not know why the third shift MA did not document Resident #5 refused his 7:00am FSBS check. -The third shift MA told her at shift change that morning (05/05/21) that Resident #5 refused his 7:00am FSBS check. -The MA did not have a response when questioned about why she would document Resident #5's 7:00am FSBS on 05/05/21 was refused. Second interview with the MA on 05/05/21 at 11:37am revealed: -Resident #5 was not in the facility for his 11:30am FSBS check. -Resident #5 signed out to go to the store which he did often. -She would have to put the FSBS sugar check on	D 358		

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hold because Resident #5 probably ate while he was out of the facility.

Interview with Resident #5 on 05/06/21 at 11:20am revealed:
-No one had checked his FSBS yesterday (05/06/21); no one had come to check his FSBS since yesterday evening (05/05/21 at 5:00pm).
-He went to the medication cart this morning (05/06/21) and the MA checked his temperature, gave him his medications and that was it.

Review of Resident #5's May 2021 eMAR revealed staff documented Resident #5's FSBS was 500 with 12 units of Novolog SSI administered on 05/05/21 at 5:00pm and there was no FSBS result documented on 05/06/21 at 7:00am.

Observations on 05/06/21 from 11:21am to 11:45am revealed:
-At 11:21am, the MA entered Resident #5's room and announced it was time for him to come to the medication cart for his medications.
-Resident #5 asked the MA to bring his medications to him in his room.
-At 11:25am, the MA returned with the medication cart.
-The MA checked Resident #5's FSBS and the result was 594.
-The MA administered 12 units of Novolog SSI.

Telephone interview with the facility's contracted PCP on 05/11/21 at 5:01pm revealed:
-She did not know some of Resident #5's FSBS checks were not done at times and that the resident was out of the facility at other times.
-Staff may have notified Resident #5's Veteran's Administration provider.
-Resident #5 had poorly controlled diabetes

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mellitus and was at increased risk of damage to his eyes, kidneys, heart and feet by not having his FSBS checked to determine if Novolog SSI should have been administered as ordered.

Interview with the Administrator on 05/07/21 at 3:00pm revealed:
-She was not aware Resident #5 reported FSBS checks were not being done verses documented refusals.
-FSBS checks should be done according to the PCP's order.

Attempted interview on 05/11/21 at 5:47pm with the medication aide (MA) who worked third shift on on 05/04/21 to 05/05/21 was unsuccessful.

Refer to interview with a medication aide (MA) on 05/10/21 at 2:30pm.

Refer to interview with a second MA on 05/11/21 at 6:11pm.

Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on 05/10/21 at 6:59pm.

Refer to interview with the Administrator on 05/11/21 at 7:48pm.

b. Review of a physician's visit form dated 04/02/21 for Resident #5 revealed:
-There was an order for Alogliptin 25mg daily. (Aloglipton is an oral medication used to treat diabetes.)
-The form was signed by the physician listed on prescription labels from the Veteran's Administration.

Review of Resident #5's April 2021 electronic

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medication administration record (eMAR) revealed:
-There was an entry for Aloglipton 25mg daily scheduled at 9:00am with a start date of 04/13/21.
-There was documentation doses were administered from 04/14/21 to 04/30/21.
-There was no documentation doses were not administered 04/03/21 through 04/13/21 and the reason not administered.

Review of Resident #5's May 2021 eMAR revealed:
-There was an entry for Aloglipton 25mg daily scheduled at 9:00am.
-There was documentation doses were administered from 05/01/21 to 05/05/21.

Observations of medications on hand for Resident #5 on 05/07/21 at 3:49pm revealed there was a prescription bottle with a pharmacy label for Aloglipton with directions to take 25mg daily.

Interview with the lead Supervisor/MA on 05/11/21 at 6:59pm revealed:
-It was to get in touch with Resident #5's provider and the pharmacy at the Veteran's Administration.
-The facility's contracted primary care provider (PCP) was Resident #5's PCP.
-She did not know who the provider was that signed the orders dated 04/02/21.
-The order form was one the facility sent with residents for outside appointments.
-Resident #5 must had had an appointment at the Veteran's Administration.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/10/21 at 6:59pm revealed:

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D 358	Continued From page 50 -The pharmacy received an order on 04/13/21 for Aloglipton 25mg daily dated 04/02/21. -The order for Aloglipton was for Resident #5's profile only, no medication was dispensed. Telephone interview with the facility's contracted PCP on 05/11/21 at 5:01pm revealed: -She thought the Veteran's Administration provider was an endocrinologist that wrote the orders for Aloglipton. -Staff may have notified Resident #5's endocrinologist or Veteran's Administration provider about any missed doses. Pharmacy event reports and PCP notifications related to Aloglipton were requested on 05/04/21 and 05/05/21 but were not provided for review prior to survey exit. Attempted interviews with the former RCC on 05/06/21, 05/07/21, and 05/10/21 were unsuccessful. Attempted telephone interview with Resident #5's Veteran's Administration provider on 05/11/21 at 1:59pm and 05/11/21 at 4:58pm were unsuccessful. Refer to interview with a medication aide (MA) on 05/10/21 at 2:30pm. Refer to interview with a second MA on 05/11/21 at 6:11pm. Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on 05/10/21 at 6:59pm. Refer to interview with the Administrator on 05/11/21 at 7:48pm.	D 358		

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D 358	Continued From page 51 c. Review of Resident #5's current FL-2 dated 08/20/20 revealed an order for omeprazole 20mg every morning. (Omeprazole is used to treat acid reflux.) Review of physician's orders dated 01/20/21 for Resident #5 revealed an order for omeprazole 20mg every morning as needed (PRN) for heartburn. Review of Resident #5's March, April and May 2021 electronic medication administration record (eMAR) revealed: -There was an entry for omeprazole 20mg daily scheduled for 7:00am. -Staff documented administering doses 03/02/21 through 03/31/21 except 03/14/21 and 03/23/21. Review of Resident #5's April 2021 eMAR revealed: -There was an entry for omeprazole 20mg daily scheduled for 7:00am. -Staff documented administering doses 04/01/21 through 04/30/21 except 04/10/21, 04/12/21, 04/19/21, 04/21/21, 04/22/21, 04/28/21 and 04/30/21. Review of Resident #5's May 2021 eMAR revealed: -There was an entry for omeprazole 20mg daily scheduled for 7:00am. -Staff documented administering doses 05/01/21 through 05/05/21 not given due to refusal on 05/04/21 and 05/05/21. Interview with the lead Supervisor/medication aide (MA) on 05/11/21 at 6:59pm revealed the former Resident Care Coordinator (RCC) would have been responsible for faxing the omeprazole	D 358		

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D 358	Continued From page 52 order to the pharmacy and entering the new order on the eMAR. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/10/21 at 6:59pm revealed the pharmacy did not have the physician's order dated 01/20/21 with the order for omeprazole 20mg daily PRN for heartburn. Telephone interview with the facility's contracted PCP on 05/11/21 at 5:01pm revealed: -She was not aware omeprazole was being administered scheduled daily for Resident #5. -She had not written an order to change omeprazole from PRN to scheduled daily. Attempted interviews with the former RCC on 05/06/21, 05/07/21, and 05/10/21 were unsuccessful. Attempted telephone interview with Resident #5's Veteran's Administration provider on 05/11/21 at 1:59pm and 05/11/21 at 4:58pm were unsuccessful. Refer to interview with a medication aide (MA) on 05/10/21 at 2:30pm. Refer to interview with a second MA on 05/11/21 at 6:11pm. Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on 05/10/21 at 6:59pm. Refer to interview with the Administrator on 05/11/21 at 7:48pm. _____ Interview with a medication aide (MA) on 05/10/21 at 2:30pm revealed:	D 358		

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	HAL096047	A. BUILDING: _____ B. WING _____	R 05/11/2021

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D 358	Continued From page 53 -MAs faxed new orders that came from the primary care provider's (PCP's) office to the pharmacy. -Orders sent directly to the pharmacy by the PCP were sent to the facility by the PCP also. -The pharmacy entered the medication orders on the electronic medication administration record (eMAR). Interview with third MA on 05/11/21 at 6:11pm revealed: -MAs were responsible for reviewing the medication cart each shift to ensure medications were on hand for administration. -The MA's were responsible for reordering medications. -The MA's were responsible for completing a medication cart audit weekly. -She did not know what the facilities medication policy was regarding missed doses of medication. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/10/21 at 6:59pm revealed: -Pharmacy staff removed orders from the eMAR after receiving an order from the PCP to discontinue the medication and/or treatment. -Pharmacy staff entered all new orders on the eMAR except with residents who were new to the facility. -Orders were received by the fax from the facility and electronically, fax and telephone order from the PCP. -She did not know all the capabilities staff had on the facility side of the eMAR system, she knew the staff were able to add orders to the eMAR. Interview with the Administrator on 05/11/21 at 7:48pm revealed: -MAs were expected to administer medications	D 358		

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D 358	Continued From page 54 according to the eMAR. -MAs were expected to document each medication given or not given and the reason if not given. -MAs were expected to contact the pharmacy immediately for any medication that was not available for administration. -MAs were expected to notify the PCP if a medication was not available and document contacting the PCP and pharmacy in the electronic charting system.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to health care and medication aide training and competency. The findings are: 1.Based on observations, interviews and record reviews, the facility failed to contact the primary care provider (PCP) for the acute and routine health care needs of 2 of 6 sampled residents (#4, #5) for multiple doses of unavailable psychiatric medications (#4); and refusals of finger stick blood sugar (FSBS) checks and	D912		

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D912	Continued From page 55 results greater than 500 mg/dl and refusals of insulin (#5). [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 ensure 1 of 4 sampled medications aides (MAs) had completed the 5 and 10-hour medication aide training and medication administration competency validation clinical skills checklist and passed the written medication aide exam prior to administering medications unsupervised to residents. [Refer to Tag 935 G.S.131D-4.5 B(b) ACH Medication Aide Training and Competency Evaluation Requirements (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 5 sampled residents (#7) who had an order for oxygen as needed had a portable oxygen tank available to take with them when out of the facility. [Refer to Tag 276 10A NCAC 13F .0902(c)(3-4) Health Care (Type B Violation)].	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the	D935		

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D935	Continued From page 56 Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure 1 of 4 sampled medications aides (MAs) had completed the 5 and 10-hour medication aide training and medication administration competency validation clinical skills checklist and passed the written medication aide exam prior to administering medications unsupervised to residents.	D935		

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D935	Continued From page 57 The findings are: Review of Staff E's, MA, personnel record revealed: -Staff E was hired on 01/13/21 as medication aide. -There was documentation Staff E completed the 15-hour medication aide training on 05/01/21 after Staff had administered medications to residents in March 2021 and April 2021. -There was no documentation Staff E completed the medication administration competency validation clinical skills checklist. -There was no documentation Staff E had taken and passed the written medication aide exam. Review of two residents March 2021 electronic medication administration records (eMARs) revealed Staff E documented medications were administered or refused on the following dates: 03/03/21, 03/07/21, 03/07/21, 03/11/21, 03/13/21, 03/16/21, 03/17/21, 03/21/21, 03/22/21, 03/25/21 and 03/27/21. Review of two residents April 2021 eMARs revealed Staff E documented medications were administered or refused on the following dates: 04/01/21, 04/04/21, 04/05/21, 04/07/21, 04/10/21, 04/15/21, 04/21/21 and 04/28/21. Review of two residents May 2021 eMARs revealed there was no documentation Staff E administered medications from 05/01/21 through 05/04/21. Interview with Staff E on 05/11/21 at 6:58am revealed she had worked third shift as a MA. Interview with the Quality Assurance Nurse on	D935		

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D935	Continued From page 58 05/11/21 at 4:30pm revealed: -There was no documentation Staff E completed the medication administration competency validation clinical skills checklist. -There was no documentation Staff E had passed the written medication aide exam. Interview with the Business Office Manager (BOM) on 05/11/21 at 8:30pm revealed: -She was responsible for ensuring staff completed MA training and competency requirements. -She and the Administrator did an audit in April 2021 of staff personnel records; she did not remember the exact date. -She found out at that time Staff E had not completed the 5 and 10-hour medication aide training and medication administration competency validation clinical skills checklist prior to administering medications unsupervised to residents. -She contacted the Licensed Health Professional Support (LHPS) Nurse on 05/07/21 to arrange completion of the medication administration competency validation clinical skills checklist for Staff E. Interview with the Administrator on 05/11/21 at 7:47pm revealed: -The BOM was responsible for ensuring training and orientation requirements were completed for MAs. -The BOM contacted the LHPS Nurse to arrange MA training for staff. -She did not know Staff E had not completed the medication administration competency validation clinical skills checklist and 5 and 10-hour medication aide training and passed the written medication aide exam prior to administering medications to residents.	D935		

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D935	Continued From page 59 -Staff E would not administer medications until training requirements were completed. _____ The facility failed to ensure Staff E had completed the 5 and 10-hour medication aide training and the medication administration competency validation clinical skills checklist and passed the written medication aide exam which resulted in the risk of medication errors. This failure was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/05/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 25, 2021.	D935		