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CARTERET HOUSE	3020 MARKET STREET NEWPORT, NC 28570

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 08/11/21-08/12/21.	{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: 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 ensure 1 of 5 (#1) sampled resident's primary care provider (PCP) was notified for a change in condition related to a worsening wound on her buttocks and coccyx (tailbone) and for new bilateral feet and ankle swelling. The findings are: Review of the Resident #1's current FL-2 dated 07/14/21 revealed: -Diagnoses included paroxysmal atrial fibrillation (irregular heart rate that commonly causes poor blood flow), and syncope (fainting). -The resident was intermittently disoriented. -She was ambulatory. -She required assistance with bathing, was incontinent of bladder and was continent with bowel.	{D 273}		

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{D 273}	Continued From page 1 Review of Resident #1's current assessment and care plan dated 08/05/21 revealed: -The resident was ambulatory with a walker. -The resident was occasionally incontinent of bladder. -She was oriented with adequate memory. -She required limited assistant with eating, toileting, ambulation, bathing, dressing, grooming, and transferring. Review of Resident #1's current Licensed Health Professional Support (LHPS) assessment dated 05/13/21 revealed: -The resident ambulated independently without difficulty from her room to the dining room. -She was able to complete her activities of daily living (ADLs) with one person staff assistance. -Her skin was warm, dry, and intact. a. Review of a physician notification form for Resident #1 dated 07/26/21 revealed: -A handwritten note was faxed to the PCP documenting "Resident's backside near tailbone is red, sore, and hurts. What can she do!". -There was a signed order in response from the PCP dated 07/27/21 to apply zinc oxide to the affected area three times per day. (Zinc Oxide is commonly used for wounds and skin irritation to provide a barrier to the skin and promote healing.) Interview with Resident #1 on 08/11/21 at 9:15am revealed: -The resident "wasn't doing too well" that day. -She slept in the recliner in the suite common area because her roommate was too loud, and she could not rest or sleep in her room. -Her buttocks and coccyx hurt because she had a sore there like a "baby would get from a diaper rash".	{D 273}		

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{D 273}	Continued From page 2 -The wound on her bottom had been there a couple of weeks and was getting worse. -She reported the sore on her coccyx to the staff. Observation of Resident #1 on 08/11/21 at 3:20pm revealed: -A mediation aide (MA) was present in Resident #1's room to assist with the observation of her buttocks and coccyx. -There was a discolored reddish/purple area on her buttocks and coccyx that measured approximately 6 inches tall and 5 inches wide and did not blanch (turn white and refill with blood) when pressed on by the MA. -In the center of the discolored area on the coccyx there was a pencil eraser sized ulcer that was open with a red wound bed and minor skin sloughing around the perimeter. Interview with Resident #1 on 08/11/21 at 3:20pm revealed: -She did not like showers, but she did like baths. -The staff tried to put cream on the painful area of her buttocks and coccyx, but "it burned like pepper", so she stopped letting them apply it. Interview with a personal care aide (PCA) on 08/11/21 at 3:40pm revealed: -The resident would refuse showers and liked her independence in bathing. -She was aware of the reddened spot on Resident #1's buttocks and coccyx but thought it was improving. -Another PCA had made her aware of the area on Resident #1's buttocks and coccyx, but she had not seen or assessed the area herself. -She had not seen the area on Resident #1's buttocks and coccyx because a PCA on another shift was responsible for bathing and performing skin assessments for the resident.	{D 273}		

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{D 273}	Continued From page 3 Interview with a medication aide (MA) on 08/11/21 at 3:35pm revealed: -There was an order to put zinc oxide cream on Resident #1's buttocks and coccyx 3-times per day, but the resident said it burned and began to decline it. -She knew the resident had an open wound within the reddened area on her buttocks and coccyx, but thought it was getting better. -The open wound bed on Resident #1's coccyx had gone from being dime size to pencil eraser size since the last time she saw it two days ago. -She had not reported the open area or medication cream refusal to Resident #1's PCP or the facility's Resident Care Coordinator and Administrator because she thought they already knew about it. Interview with a second MA on 08/12/21 at 12:10pm revealed: -She was responsible for overseeing personal care for the residents and contacting the resident's PCP for any issues or concerns during her shifts at the facility. -She knew Resident #1 slept in a recliner and had tried to get her to sleep in her bed, even offering to purchase the resident a mattress topper to make the bed more comfortable. -The resident had previously told her the bed hurt her back and refused to sleep in the bed. -The staff on the previous shift had reported to her that Resident #1 had increased redness and an open sore on her buttocks and coccyx after being made aware by survey staff. -She had last seen the reddened area on Resident #1's buttocks and coccyx 2-3 days ago and there had been a dime size reddened area with no open sore. -Resident #1 seemed more tired over the last few	{D 273}		

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{D 273}	Continued From page 4	{D 273}		

days and used to walk more.
-She had contacted Resident #1's PCP that afternoon, 08/12/21, about the resident's increased redness and open wound on her buttocks and coccyx and received orders for a home health nurse to come in to help treat the area; the PCP would see the resident the following Wednesday for follow-up.
-She had not reported Resident #1's buttocks and coccyx redness or her concerns about the resident to the PCP prior to today, 08/12/21, she did not know why.

Interview with the supervising MA on 08/12/21 at 7:00am revealed:
-She was the lead MA at night and in charge of overseeing PCAs and MAs when working and the Resident Care Coordinator and Administrator were unavailable.
-Resident #1 told her about a spot on her buttocks and coccyx that was sore about two weeks ago.
-Resident #1 had said she reported the spot to another MA before reporting it to her, but nothing happened to help her with the issue.
-She looked at the area on Resident #1's buttocks and coccyx the night the resident reported it and it was reddened about the size of a small orange at that time with no open wound.
-She was aware Resident #1 slept in a recliner in the suite's common area instead of her bed.
-She had tried to get Resident #1 to go to her bed last night, but the resident said she could not sleep in her bed.
-Resident #1 had never complained about her roommate before, but if she knew the resident was unable to sleep in her bed due to the roommate, she would have found her a different room.
-When she looked at the area on Resident #1's

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buttocks and coccyx again last night (08/11/21), it was worse, measuring approximately 5 inches x 5 inches and had an open sore the size of a pencil eraser in the center of it.
-She was not sure when the open sore appeared on Resident #1's buttocks and coccyx.
-Sleeping in a recliner could have contributed to the worsening of the area on Resident #1's buttocks and coccyx.
-She knew Resident #1 had zinc oxide cream prescribed for the area on her buttocks and coccyx.
-She knew Resident #1 had been refusing the zinc oxide cream for the spot on her buttocks and coccyx.
-She had not reported Resident #1's open sore and refusal of the zinc oxide cream to anyone because she was busy and forgot.
-She should have reported Resident #1's open sore and refusal of the zinc oxide cream to the PCP immediately.

Interview with Resident #1's PCP on 08/12/21 at 9:20am revealed:
-She had been in the facility assessing residents yesterday, 08/11/21, but had not seen Resident #1 because she was not notified of any reason the resident would require assessment.
-She was aware that the resident slept in a recliner but was under the impression the resident chose to do that because she sometimes felt short of breath.
-She was aware that Resident #1 had refused the zinc oxide cream to treat the area on her buttocks and coccyx but had not been notified that the area had gotten worse and bigger, or that there was an open sore in the area.
-If she had been made aware that the area on the resident's buttocks and coccyx had worsened with an open sore, she would have provided

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

orders for zinc cream, dry dressings, possible home health, and to ensure the resident was moving around more.
-She expected the facility staff to notify her of significant changes such as a worsening wound immediately.
-If she had been made aware that the area on the resident's buttocks and coccyx had worsened, she also would have assessed the resident yesterday, 08/11/21.

Interview with the Resident Care Coordinator (RCC) on 08/12/21 at 11:04am revealed:
-She was not aware of the worsening reddened area or open wound on Resident #1's buttock and coccyx until it had been brought to her attention.
-She expected changes in condition to be reported immediately to the PCP.
-She was not aware that Resident #1 routinely slept in a recliner.
-The reddened area and open wound on Resident #1's buttocks and coccyx should have been documented in the resident's progress notes and bath sheets, then faxed via notification to the PCP.
-There was no documentation or notification in the record regarding Resident #1's reddened area and open wound on her buttocks and coccyx.

Interview with the Administrator on 08/12/21 at 10:17am and 3:30pm revealed:
-She was not aware that Resident #1's area on her buttocks and coccyx had gotten worse.
-She was concerned about Resident #1's wound and that the resident would need home health to treat the wound.
-The facility staff should have notified the PCP, her, and the RCC right away when the area on Resident #1's buttocks and coccyx worsened.

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{D 273}	Continued From page 7 -Resident #1's PCP would have seen and assessed the resident yesterday, 08/12/21, if she had been made aware that the area had gotten worse. b. Review of a physician progress note for Resident #1 dated 06/30/21 revealed: -She was seen by the primary care provider (PCP) for foot pain. -She had a bruise on her left foot in the arch and described pain upon palpation. -She had no recollection of how the bruise appeared, but she had not changed shoes recently. -She reported generalized pain in both feet some of the time. -There was no documentation or assessment of the resident's feet being swollen. -There was a plan to refer the resident to podiatry for further evaluation. -There were no other complaints or concerns voiced by the resident or staff at that time. Review of a physician order for Resident #1 dated 06/30/21 revealed there was a handwritten order signed by the PCP for the resident to see podiatry for bilateral foot pain. Review of hospital emergency room (ER) discharge instructions for Resident #1 dated 07/17/21 revealed: -The resident was seen in the ER for dyspnea (difficulty breathing). -She was discharged and to follow up with the PCP within 1-4 days. -The ER discharge instructions were faxed to the PCP on 07/19/21 -She was scheduled to see the PCP on 07/21/21. Review of a physician progress note for Resident	{D 273}		

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{D 273}	Continued From page 8 #1 dated 07/21/21 revealed: -The resident was seen for a post ER follow up visit for dyspnea. -The dyspnea occurred randomly and was resolved by getting up and moving around. -Exertion did not cause shortness of breath and her oxygen saturations were normal. -Her lung sounds were clear with normal respiratory effort. -Her heart had a regular rate and rhythm without murmur or gallop. -She had a diagnosis of hypertension. -There was no documentation or assessment of the resident's feet being swollen. -There were no further concerns or complaints from the resident or staff at that time. -There was an order to continue to monitor the resident and to follow up in 3-months or sooner as needed. Review of Resident #1's bath sheet and body evaluation dated 07/27/21 revealed: -The resident was noted to have swelling in her feet and ankles that required follow-up. -There was a handwritten note that the resident had an appointment with podiatry on 07/29/21. Review of Resident #1's progress note dated 07/29/21 revealed: -The resident was seen by podiatry on that day (07/29/21). -The resident had not been experiencing any pain at the appointment. -The facility was to notify the podiatrist when the resident had pain again. -The resident was instructed to not walk around barefoot and to always wear shoes. Observation of Resident #1 on 08/11/21 at 9:17am revealed:	{D 273}		

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{D 273}	Continued From page 9 -The resident was sitting in a recliner in the suite's common area. -The resident had on regular socks but no shoes; her feet were not elevated. -Her shoes were on the floor next to her feet. -The resident's feet and ankles had obvious swelling bilaterally. -The right foot was slightly more swollen than the left foot and the skin was taught and shiny on the top of the right foot. -Her toes appeared normal in alignment and placement. -Both feet were pale in color bilaterally. -There were indentations in the resident's ankles from her socks revealing edema. Interview with Resident #1 on 08/11/21 at 9:15am revealed: -The resident "wasn't doing too well" that day. -Her feet were swollen, and she could not get her tennis shoes on like normal. -She was supposed to wear shoes every day as directed by her doctor at her last appointment. -It was painful to walk on her feet, so the staff had brought her breakfast to her room. -She reported the swelling and foot pain to the staff. -She had slept in the recliner in the suite common area because her roommate was too loud, and she could not rest or sleep in her room. Observation of Resident #1 on 08/12/21 at 11:57am revealed: -The resident was sitting in a recliner in the suite common area. -The resident had on socks and bedroom slippers; her feet were not elevated. -The resident's feet and ankles were more swollen bilaterally than the previous day. -The resident's skin was bulging over the	{D 273}		

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bedroom slippers through the socks and there were indentations on the resident's feet from the bedroom slippers that took approximately 10 seconds to resolve after removing the slippers.
-The left foot was slightly more swollen than the right foot.
-The skin was taught and shiny on both feet and each individual toe bilaterally.
-The toes on the left foot were separated due to the swelling and did not lay in natural alignment.
-Both feet were slightly discolored (pink/purple hue) from the middle of the foot to the toes.
-There was pitting edema that took great than 6 seconds to return to baseline noted to both feet when the resident applied pressure to her foot, upon request, and then released for assessment and observation.

Interview with Resident #1 on 08/12/21 at 11:57am revealed:
-Her feet were more swollen and painful today, 08/12/21.
-She was unable to eat in the dining room that day as she normally would because her feet hurt too much to walk.

Interview with a personal care aide (PCA) on 08/11/21 at 3:40pm revealed she had reported swelling in Resident #1's feet and requested compression stockings for the resident to the medication aide (MA) approximately 1-2 weeks ago.

Interview with a second PCA on 08/12/21 at 12:08pm revealed:
-Resident #1 was eating lunch in her room that day, 08/12/21, but he did not know why.
-Resident #1 normally ate lunch in the dining room, but he thought maybe she wasn not feeling well.

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{D 273}	Continued From page 11 Interview with a MA on 08/11/21 at 3:35pm and 3:46pm revealed: -The swelling in Resident #1's feet and ankles was new over the previous two days. -Due to the swelling, the resident was unable to wear her shoes. -She thought she wrote a note to Resident #1's PCP to notify her of the swelling but she could not remember. -She had not reported the swelling in Resident #1's feet to the Resident Care Coordinator or Administrator; she did not know why. -She had not requested any interventions for Resident #1 such as compression stockings to help with the swelling because it was the PCP's decision to implement interventions. Interview with a second MA on 08/12/21 at 12:10pm revealed: -She was responsible for overseeing personal care for the residents and contacting the resident's PCP for any issues or concerns. -She knew Resident #1 slept in a recliner and had tried to get her to sleep in her bed, even offering to purchase the resident a mattress topper to make the bed more comfortable. -The resident had told her the bed hurt her back and refused to sleep in the bed. -Resident #1 had slept in the recliner again last night, 08/11/21, and had complained that morning, 08/12/21, that her feet hurt. -The staff on the previous shift had reported to her that Resident #1 had increased swelling in her feet after being made aware by survey staff. -She had contacted Resident #1's PCP that afternoon, 08/12/21, about the resident's feet and ankle swelling. -She received orders to ensure the resident's feet remained elevated and the PCP would see the	{D 273}		

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resident on the following Wednesday.
-She had noticed swelling in Resident #1's feet over the previous week come and go, but the swelling in the resident's feet today, 08/12/21, was the worst she had ever seen it.
-Resident #1 seemed more tired over the last few days and used to walk more.
-She had not reported the swelling or any of her concerns about Resident #1 to the PCP prior to today, she did not know why.

Interview with the supervising MA on 08/12/21 at 7:00am revealed:
-The swelling in Resident #1's feet and ankles was new, and she had never noticed swelling in the resident feet before.
-When she assessed Resident #1 approximately one week prior, the resident did not have any swelling in her feet or ankles.
-She was aware Resident #1 slept in a recliner in the suite's common area instead of her bed.
-She had tried to get Resident #1 to go to her bed last night, but the resident said she couldn't sleep in her bed.
-She was concerned about the swelling in Resident #1's feet last night and tried to get the resident to elevate her feet in the recliner, but the resident refused.
-She did not report the swelling in Resident #1's feet last night because she was busy, and she forgot.
-She should have reported the swelling in Resident #1's feet to the PCP immediately.
-She was responsible for reviewing resident bath sheets and reporting any issues documented on the bath sheets to the PCP, but she hadn't done them in the last two weeks and was not sure who was assuming that responsibility when she had not done them.
-She did not know Resident #1 had documented

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{D 273}	Continued From page 13 swelling on her bath sheet from 07/27/21 and was unsure if it had been reported to the PCP. Review of Resident #1's record revealed there was no notification on file notifying the PCP of swelling in the resident's feet and ankles. Interview with Resident #1's PCP on 08/12/21 at 9:20am revealed: -She had been in the facility assessing residents yesterday, 08/11/21, but had not seen Resident #1 because she was not notified of any reason the resident would require assessment. -She was aware that the resident slept in a recliner but was under the impression she chose to do that because she sometimes felt short of breath. -She was aware that the resident had some mild chronic swelling in her feet, but her assessments of the resident previously revealed good pulses in the feet and her lab work had been negative for concern at previous visits. -She was not aware that the resident was unable to wear shoes due to the swelling in her feet. -She expected the facility staff to notify her of significant changes such as feet and ankle swelling immediately. -She would have assessed the resident yesterday, 08/11/21, had she been notified that the resident had increased swelling. Interview with the Resident Care Coordinator (RCC) on 08/12/21 at 11:04am revealed: -She was not aware of Resident #1's feet and ankle swelling until it had been brought to her attention. -She expected changes in condition to be reported to the resident's PCP immediately. -She was not aware that Resident #1 routinely slept in a recliner.	{D 273}		

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{D 273}	Continued From page 14 -Resident #1's feet and ankle swelling should have been documented in the resident's progress notes and bath sheets, then faxed via notification to the PCP. -There was no documentation or notification in the record regarding Resident #1's feet and ankle swelling other than the bath sheet dated 07/27/21 which noted that the resident was to be seen by the podiatrist. Interview with the Administrator on 08/12/21 at 10:17am and 3:30pm revealed: -She was not aware that Resident #1's feet and ankles were swollen. -The facility staff should have notified the PCP, her, and the RCC right away when Resident #1's feet and ankle swelling had been identified. -Resident #1's PCP would have seen and assessed the resident yesterday, 08/12/21, if she had been made aware of the resident's swelling. _____ The facility failed to follow-up and notify Resident #1's PCP of a worsening reddened area and open wound on the resident's buttocks and coccyx and bilateral feet and ankle swelling was detrimental to the health and welfare of the resident's acute health care needs and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/12/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 26, 2021.	{D 273}		
{D 310}	10A NCAC 13F .0904(e)(4) Nutrition and Food Service	{D 310}		

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{D 310}	Continued From page 15 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure 2 of 5 residents sampled (#4 and #6) were served therapeutic diets as ordered related to an order for chopped meats and no juice with pulp (#4) and a pureed diet (#6). The findings are: 1. Review of Resident #4's current FL-2 dated 07/22/21 revealed: -Diagnoses included chronic obstructive pulmonary disease, hypertension, macular degeneration, polymyalgia rheumatica, iron deficiency, tobacco use, and actinic keratosis. -There was an order for a regular diet with chopped meats. -Resident #4 was not to have any nuts, seeds or juice with pulp. Review of the therapeutic diet list posted in the dining room on 08/12/21 at 7:58 am revealed: -Resident #4 was to be served a regular diet with ground meats. -Resident #4 was to be served no nuts, seeds, or juice with heavy pulp.	{D 310}		

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{D 310}	Continued From page 16 Observation of Resident #4 on 08/12/21 from 7:15am to 7:48am revealed: -Resident #4 was in her room seated at the recliner. -The Dietary Manager brought in Resident #4's breakfast plate. -Resident #4's plate contained scrambled eggs, crushed pineapple, and 2 pieces of whole bacon. -Resident #4 was served coffee and orange juice. -Resident #4 consumed 100% of her meal. Interview with Resident #4 on 08/12/21 at 7:48am revealed: -She sometimes got "choked up" on certain tough meats. -She was able to suck on the bacon to soften it enough for her to be able to eat it. -She did not notice the pulp in the orange juice this morning. -She was not supposed to have juices with pulp because it upsets her stomach. Observation of the juice dispenser in the kitchen on 08/12/21 at 2:55pm revealed there was pulp in the orange juice. Interview with a cook on 08/12/21 at 2:55pm revealed: -She was not aware that the orange juice contained pulp. -She normally worked lunch and dinner. -Resident #4 was on a regular diet with ground meats. Interview with the Dietary Manager on 08/12/21 at 9:03am revealed: -The therapeutic diet list posted in the dining room was correct. -Resident #4 was on a regular diet with ground meats.	{D 310}		

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{D 310}	Continued From page 17 -Resident #4 should not have been served whole pieces of bacon. -The only orange juice that was available for order had pulp. -It was her responsibility to ensure that Resident #4 was served ground meats and juice with no pulp. Interview with the Administrator on 08/12/21 at 3:30pm revealed: -Resident #4 argued at times with the dietary staff if they gave her ground meats with her meals. -She expected Resident #4 to be served ground meats as ordered. -She expected Resident #4 not to be served juice with pulp as ordered. Attempted telephone interview with Resident #4's primary care provider (PCP) on 08/12/21 at 9:15am was unsuccessful. 2. Review of Resident #6's current FL-2 dated 11/06/20 revealed diagnoses included hypertension, polycythemia vera, muscle spasms, hyperlipidemia, and cerebral vascular accident with left hemiparesis. Review of a physician's order dated 07/23/21 revealed: -There was an order to discontinue Resident #6's mechanical soft diet. -There was an order to start Resident #6 on a pureed diet. Review of the therapeutic diet list posted in the dining room on 08/12/21 at 7:58 am revealed Resident #6 was to be served a pureed diet. Observation of the dining room on 08/12/21 from 7:30 am until 8:40am revealed:	{D 310}		

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{D 310}	Continued From page 18 -Resident #6 was served orange juice and coffee at 7:30am. -Resident #6 was served a rice cereal with milk at 7:35am. -Resident #6 had a non-productive, strong cough while eating the cereal. -At 7:40am, while eating his cereal, Resident #6 coughed up the cereal. -At 7:43am, was served ground bacon, grits, and eggs. -Resident #6 continued coughing throughout the breakfast meal. -Resident finished his breakfast at 8:29am. Interview with a medication aide (MA) on 08/12/21 at 7:55 am revealed: -Resident #6 had a chronic cough. -Resident #6 did not have any trouble swallowing his medication when they were crushed in pudding. Interview with the Dietary Manager on 08/12/21 at 9:03am revealed: -She had learned about pureed diets approximately 20 years ago when she working in a skilled nursing facility. -Staff had a manual in the kitchen that described the different dietary consistencies that included pureed. -She struggled to find food that she was able to puree. -It was difficult for her to meet the dietary needs of Resident #6. -She discussed specific resident's dietary needs with the Resident Care Coordinator (RCC) or the Administrator. -She could not recall if she discussed her struggle to meet Resident #6's dietary needs with the RCC or Administrator.	{D 310}		

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{D 310}	Continued From page 19 Interview with the RCC on 08/12/21 at 11:04am revealed: -She was not aware that Resident #6 did not receive a pureed diet. -She was not aware the Dietary Manager had difficulty preparing a pureed diet for Resident #6. Interview with the Administrator on 08/12/21 at 3:30pm revealed: -She expected Resident #6 to receive the pureed diet as ordered. -She was not aware the Dietary Manager had difficulty preparing a pureed diet for Resident #6. -She was going to reach out to corporate services for additional training for the dietary staff on therapeutic diets. Interview with Resident #6's primary care provider (PCP) on 08/12/21 at 9:20am revealed: -She was aware of Resident #6's cough. -Resident #6's cough was chronic and may related to his tobacco use. -She was not concerned with Resident #6 aspirating. -Resident #6 had multiple diagnostic tests that ruled out aspiration. -She consulted a gastro-intestinal doctor to see Resident #6. -She expected staff to served Resident #6 a pureed diet as ordered. Based on observation, interviews, and record reviews, it was determined that Resident #6 was uninterviewable.	{D 310}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration	{D 358}		

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{D 358}	Continued From page 20 (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: Based on observations, interviews, and record reviews, the facility failed to ensure the administration of medications as ordered for 3 of 5 sampled residents (#1, #2, and #4) regarding an inhaler medication for asthma and chronic obstructive pulmonary disease (COPD) (#1), nystatin cream (#2), and eye drops (#4). The findings are: 1.Review of the Resident #1's current FL-2 dated 07/14/21 revealed: -Diagnoses included asthma, paroxysmal atrial fibrillation (irregular heart rate that commonly causes poor blood flow) and syncope (fainting). -There was an order for Advair HFA aerosol inhaler 115-21 mcg/actuation, 1 puff twice daily. (Advair is a medication used to treat asthma and COPD.) Review of a subsequent medication order for Resident #1 dated 07/15/21 revealed there was an order for Advair HFA aerosol inhaler 115-21 mcg/actuation, 2 puffs twice daily. Review of Resident #1's July 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Advair HFA 115-21 mcg/actuation, 1 puff twice daily scheduled at	{D 358}		

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{D 358}	Continued From page 21 8:00am and 8:00pm that began on the evening of 07/06/21. -The Advair HFA 115-21 mcg/actuation was documented as administered with 1 puff twice daily as ordered at 8:00am and 8:00pm from 07/06/21-07/15/21. -There was an entry for Advair HFA 115-21 mcg/actuation 2 puffs with a total frequency of twice daily, once in the morning and once in the evening beginning on 07/16/21. -The entry for Advair HFA 115-21 mcg/actuation 2 puffs twice daily had duplicate scheduled administration times in both the morning (8:00am and 8:00am) and the evening (5:00pm and 8:00pm). -There was an entry for Advair HFA 115-21 mcg/actuation 2 puffs twice daily, once in the morning and once in the evening with clarified administrations times of 8:00am and 9:00pm that began on 07/30/21. -The Advair HFA 115-21 mcg/actuation 2 puffs twice daily was documented as administered three times on 07/16/21 at 9:00am, 5:00pm, and 8:00pm. -The Advair HFA 115-21 mcg/actuation 2 puffs twice daily was documented as administered three times on 07/17/21 at 8:00am, 5:00pm, and 8:00pm. -The Advair HFA 115-21 mcg/actuation 2 puffs twice daily was a documented as administered one time on 07/18/21 at 8:00am. -The Advair HFA 115-21 mcg/actuation 2 puffs twice daily was documented as administered two times, both in the evening, on 07/19/21 at 5:00pm and 8:00pm. -The Advair HFA 115-21 mcg/actuation 2 puffs twice daily was documented as administered three times on 07/20/21 - 07/23/21 at 8:00am, 5:00pm, and 8:00pm. -The Advair HFA 115-21 mcg/actuation 2 puffs	{D 358}		

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{D 358}	Continued From page 22	{D 358}		

twice daily was documented as administered four times on 07/24/21 at 8:00am twice, 5:00pm, and 8:00pm.
-The Advair HFA 115-21 mcg/actuation 2 puffs twice daily was documented as administered three times on 07/25/21 - 07/29-21 at 8:00am, 5:00pm, and 8:00pm.
-There was documentation that one dose was held each morning at 8:00am from 07/17/21-07/18/21, 07/20/21-07/23/21, and 07/25/21-07/30/21 due to a duplicate order.
-There was documentation that two doses were held the morning of 07/19/21 due to duplicate orders.
-There was no documentation that any doses were held due to duplicate orders on 07/24/21 causing the resident to receive four doses.
-There was documentation on 07/19/21 and 07/20/21 that the medication needed clarification on administration times.
-Resident #1 received 14 extra doses (1-2 extra doses each day) of Advair HFA 115-21 mcg/actuation 2 puffs 13 out of 14 days from 07/16/21-07/29/21.
-Resident #1 did not receive enough doses (only 1 dose instead of 2 doses) 1 out of 14 days on 07/18/21.

Observation of Resident #1's medications on hand on 08/11/21 at 3:20pm revealed:
-There was an inhaler of Advair HFA 115-21 mcg/actuation fill on 07/26/21 for 2 puffs twice daily in the morning and the evening.
-There were 105 puffs remaining in the Advair inhaler.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/12/21 at 2:35pm revealed:
-The pharmacy had previously filled Resident #1's

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{D 358}	Continued From page 23 Advair HFA 115-21 mcg/actuation inhaler on 07/03/21 with 120 puffs. -The Advair inhaler filled on 07/03/21 should have lasted Resident #1 through 08/09/21. -Resident #1's Advair HFA 115-21 mcg/actuation inhaler was refilled on 07/26/21 with 120 puffs at the request of the facility. -It was hard to say when the facility had opened and began using the inhaler that had been filled on 07/26/21, but if the facility used the inhaler filled on 07/03/21 as directed, the inhaler filled on 07/26/21 should have had 114 puffs remaining. -According the amount of puffs remaining in Resident #1's current inhaler, the resident had received 9 extra doses of Advair medication at some point. -Too much Advair medication would cause a headache and leave the resident at higher risk of developing upper respiratory infections. Telephone interview with Resident #1's primary care provider (PCP) on 08/12/21 at 9:20am revealed: -The resident slept in a recliner due to being short of breath because she had asthma and COPD. -She had been made aware via fax about one week ago that the resident had received extras doses of Advair HFA 115-21 mcg/actuation inhaler. -She expected the facility to administer medications as ordered. -Advair HFA 115-21 mcg/actuation inhaler was short acting and she was not concerned about the resident. Interview with a medication aide (MA) on 08/12/21 at 12:10pm revealed: -The MAs were responsible for administering medications to residents as ordered on their shifts.	{D 358}		

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{D 358}	Continued From page 24 -She did not know Resident #1 had duplicate administrations of Advair in July 2021. Interview with a MA on 08/12/21 at 7:12am revealed: -MAs were often distracted during medications passes due to other issues that came up they were responsible for handling. -If a medication was documented on a residents MAR, it was safe to assume the medication had been administered to the resident. -If duplicate administration times were observed on a resident's eMAR, it should have been reported to the Resident Care Coordinator (RCC) immediately. -MAs may not have noticed duplicated administration times on Resident #1's eMAR because they usually only review medications due at the time they are actively administering medications. -There was no process in place to require MAs to review the eMAR to ensure medications were being given accurately per the order. -Resident #1's duplicate medication administrations should have been caught during cart audits which were done Mondays-Thursdays each week by the MAs. Review of the facility's medication cart audit for Resident #1 dated 07/20/21 revealed there were no deficiencies or concerns regarding Resident #1's Advair HFA 115-21 mcg/actuation inhaler's order or administration times. Review of the facility's medication cart audit for Resident #1 dated 07/27/21 revealed there were no deficiencies or concerns regarding Resident #1's Advair HFA 115-21 mcg/actuation inhaler's order or administration times.	{D 358}		

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{D 358}	Continued From page 25 Interview with the RCC on 08/12/21 at 11:04am revealed: -It was the MAs responsibility to administer medications accurately as ordered. -She expected the MAs to recognize and report any duplicate administration times to her immediately and administer medications accurately as ordered. -She caught the duplication error on Resident #1's MAR on or around 07/30/21 when she pulled a mediation compliance report. -She corrected the error immediately and notified Resident #1's PCP of the duplicate administrations on 08/01/21. Interview with the Administrator on 08/12/21 at 3:30pm revealed: -She expected staff to administer medications as ordered by the prescribing provider. -She expected medications orders to be administered accurately as ordered. 2. Review of Resident #2's current FL-2 dated 03/25/21 revealed diagnoses include hemiparesis, muscle weakness, aphasia following cerebral infarct, diabetes type 2, heart failure, atrial flutter, and cerebral vascular accident with right sided deficit. Review of a physician order dated 07/27/21 revealed an order for Resident #2 to receive Nystatin cream, three times a day below left breast for 7 days total (Nystatin is used to treat infection). Review of Resident #2's July 2021 electronic medication record (eMAR) revealed:	{D 358}		

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{D 358}	Continued From page 26 -There was an entry for Nystatin cream 100,00 unit/gram, apply three times daily below both breasts for 7 days. -Nystatin cream 100,00 unit/gram, apply three times daily below both breasts for 7 days was documented as administered on 07/28/21 through 07/31/21. Review of Resident #2's August 2021 eMAR revealed: -There was an entry for Nystatin cream 100,00 unit/gram, apply three times daily below both breasts for 7 days. -Nystatin cream 100,00 unit/gram, apply three times daily below both breasts for 7 days, was documented as administered three times a day on 08/01/21 through 08/05/21. -Nystatin cream 100,00 unit/gram, apply three times daily below both breasts for 7 days, was documented as administered two times on 08/06/21 and 08/08/21. -Nystatin cream 100,00 unit/gram, apply three times daily below both breasts for 7 days, was documented as administered one time on 08/09/21 and 08/10/21. Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/12/21 at 2:35pm revealed facility staff was responsible for inputting a stop date on orders because a lot of the time it was dependent on when the medication arrived at the facility. Interview with Resident #2 on 08/12/21 at 9:25am revealed: -She had an "irritated area" under her breasts that improved with the Nystatin cream. -Some of the medication aides (MA) continued to put on her Nystatin cream but she had not been receiving it three times day lately.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL016018	A. BUILDING: _____ B. WING _____	R-C 08/12/2021

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{D 358}	Continued From page 27 -She could not recall the last time she received the Nystatin cream three times a day. Interview with the RCC on 08/12/21 at 11:04am revealed: -She was responsible for approving a new medication after the pharmacy has entered the order information into the electronic system. -The pharmacy would sometimes enter a stop date on medications, but she was responsible for ensuring they were complete and accurate. -Resident #2's Nystatin cream did not have a stop date entered. -Resident #2's Nystatin cream should have had a stop date of 08/03/21. -The MA's should have alerted her if they saw the medication being continued on the eMAR pasted the order. Telephone interview with Resident #2's primary care provider on 08/12/21 at 9:20am revealed: -She expected medication orders to be completed as orders, including stop date. -Resident #2's area of irritation under her breasts had improved with the Nystatin cream. -She was not concerned that the resident received 12 additional doses of the Nystatin cream. Interview with the Administrator on 08/12/21 at 3:30pm revealed it was the RCC's responsibility to ensure that orders were correct and complete on the eMAR to include stop dates. 3. Review of Resident #4's current FL-2 dated 07/22/21 revealed: -Diagnoses included chronic pulmonary obstructive disease, hypertension, macular degeneration, polymyalgia rheumatica, iron deficiency, tobacco use and actinic keratosis.	{D 358}		

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{D 358}	Continued From page 28 -There was an order for Refresh Tears 0.5%, apply to both eyes three times a day (Refresh Tears are used to treat dry eyes). Review of Resident #4's physician order dated 07/09/21 revealed there was an order to discontinue Refresh Tears 0.5%. Review of Resident #4's July 2021 electronic medication administration record (eMAR) on 08/11/21 revealed: -There was an entry for Refresh Tears 0.5%, three times a day, instill 1 drop in both eyes. -Refresh Tears 0.5% was documented as administered 89 times out of 93 opportunities from 07/01/21 to 07/31/21. -Refresh Tears 0.5% was not discontinued from the eMAR on 07/09/21, as ordered. -Refresh Tears 0.5% was documented as administered 33 times after it was discontinued on 07/09/21. Interview with Resident #4 on 08/12/21 at 7:48am revealed: -She was having a "runny nose" in the beginning of July 2021. -She thought that the Refresh Tears were causing her runny nose and that she might be allergic. -She was not sure if the Refresh Tears were helpful to her, but she continued to get them. Interview with a medication aide (MA) on 08/12/21 at 7:12am revealed: -Resident #4 was not allergic to Refresh Tears. -She was not aware that the Refresh Tears were discontinued on 07/09/21. -It was the Resident Care Coordinator's (RCC) responsibility to discontinue medications from the eMAR.	{D 358}		

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{D 358}	Continued From page 29 Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/12/21 at 2:35pm revealed: -The facility was responsible for discontinuing medications on the eMAR. -When the facility faxed a discontinue order to the pharmacy the pharmacist removed it from the resident's profile. -The pharmacy never received a discontinue order for Resident #4's Refresh Tears 0.5% on 07/09/21. -Refresh Tears 0.5% were still active on Resident #4's profile. Interview with the RCC on 08/12/21 at 11:04am revealed: -It was her responsibility to remove a medication from the eMAR and fax the order to the pharmacy when it was discontinued. -She missed faxing the order to discontinue Resident #4's Refresh Tears on 07/09/21. -She did not remove the Refresh Tears 0.5% from Resident #4's eMAR because it was an oversight on her part. Interview with the Administrator on 08/12/21 at 3:30pm revealed: -It was the RCC's responsibility to discontinue medications on the eMAR and fax the order to the pharmacy. -She expected Resident #4's eMAR to be accurate to include removal of Refresh Tears 0.5% as ordered by the primary care provider (PCP). Attempted telephone interview with Resident #4's primary care provider (PCP) on 08/12/21 at 9:15am was unsuccessful.	{D 358}		

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D912	Continued From page 30	D912		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to health care. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 5 (#1) sampled resident's primary care provider (PCP) was notified for a change in condition related to a worsening wound on her buttocks and coccyx (tailbone) and for new bilateral feet and ankle swelling. [Refer to Tag D273, 10A 13F .0902(b) Health Care (Type B Violation)]	D912		