Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068035	A. BUILDING: _____ B. WING _____	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF HILLSBOROUGH	1911 ORANGE GROVE ROAD HILLSBOROUGH, NC 27278

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 11/16/21 and 11/17/21.	D 000	Responses to cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in this Statement of Deficiencies of Corrective Action Report: the Plan of Correction is prepared solely as matter of compliance with state law.	
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure that hot water temperatures were maintained at 100° to 116° degrees Fahrenheit (F) for 6 of 6 fixtures (6 sinks) in resident's private bathrooms and a common residents' bathroom located on the A, B C and D halls with temperatures of 80°degrees F to 86° degrees F resulting in a delay in residents provided showers or refusing showers. The findings are: 1. Observation of resident room A11 on the A hall on 11/16/21 at 9:45am revealed: -One resident resided in room A11. -There was a bathroom attached to room A11 that was not shared. -The hot water temperature at the bathroom sink was 82 degrees F after running the hot water for 5 minutes.	D 113	ED has contracted with a vendor to replace water heaters to ensure water temperatures are within regulation. Maintenance Director and/or designee will monitor and record water temperatures on a weekly basis to ensure temperatures are maintained at a minimum of 100 degrees F.	1/7/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director 12-17-21

RECEIVED AND ACKNOWLEDGED 12/21/21 Catherine Prater

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D 113	Continued From page 1 Interview with the resident who resided in room A11 on 11/16/21 at 9:50am revealed: -The hot water temperature in the bathroom had been cold since the new owners took over in November 2021. -She had to let the hot water run even longer for her take a shower. -Most days there was no hot water during the morning when the kitchen and laundry were busy. -There was a leak about two weeks ago and the hot water was off for part of the day, maybe 6 hours and residents were told pipes were worked on at that time. Observation of resident room B2 on the B hall on 11/16/21 at 10:05am revealed: -One resident resided in room B2. -There was a bathroom attached to room B2 that was not shared. -The hot water temperature at the bathroom sink was 80 degrees F after running the water for 5 minutes. Interview with the resident in room B2 on 11/16/21 at 10:10am revealed: -For the past couple of weeks, the water was always cold in the morning when staff were cooking in the kitchen. -She liked to shower late in the evening but even then, she had to let the hot water run for a long time. -There was a leak about two weeks ago and the facility was working on pipes and that was what she was told by the medication aide (MA) and there would be no hot water that day for 6 to 8 hours. Based on calibration of the surveyor's thermometer on 11/16/21 at 11:30am revealed	D 113		

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D 113	Continued From page 2 the thermometer calibrated at 32 degrees F. Interview with the Maintenance Director on 11/16/21 at 11:15am revealed he had turned the two working hot water heaters up to 170 degrees F to try and compensate for the two water heaters that were not working. Observation of the Maintenance Director on 11/16/21 at 11:45am revealed he was on the B hall checking hot water temperatures in various rooms. Observation of the contracted plumber on 11/17/21 at 10:00am revealed him in the mechanical room working on pipes above the facility's four water heaters. A second recheck of the hot water temperature in room A11 on 11/17/21 at 4:03pm revealed: -The hot water at the sink had to run for 5 minutes and reached a temperature of 86 degrees F. -After running the hot water at the sink in room A11 for 5 more minutes the hot water temperature reached 110 degrees F. A second recheck of the hot water temperature in room B2 on 11/16/21 at 4:19pm revealed the hot water temperature reached 108 degrees F after running for 10 minutes. Refer to interview with the Maintenance Director on 11/16/21 at 10:54am. Refer to interview with the Maintenance Director on 11/16/21 at 11:15am. Refer to interview with the contacted plumber on 10/17/21 at 12:00pm.	D 113		

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D 113	Continued From page 3 Refer to interview with the Administrator on 11/17/21 at 3:25pm. 2. Observation of resident room D16 on the D hall on 11/16/21 at 9:35am revealed: -One resident resided in room D16. -There a bathroom attached to room D16 that was not shared. -The hot water temperature at the bathroom sink was 93 degrees F after running the hot water for 5 minutes. Interview with the resident who resided in room D16 on 11/16/21 at 9:44am revealed: -The hot water temperature in the bathroom was always cold. -He had to let the water run for "quite a long time" just to get the hot water warm enough for him to shave. -He had to let the hot water run even longer for him take a shower. -Some days there was no hot water at all. -Two weeks ago, the hot water was off for two days. -No one at the facility told him why there was no hot water, but other residents said there had been a water leak. Observation of resident room D9 on the D hall on 11/16/21 at 9:49am revealed: -One resident resided in room D9. -There was a bathroom attached to room D9 that was not shared. -The hot water temperature at the bathroom sink was 80 degrees F, after running the water for 8 minutes. Interview with the resident in room D9 on 11/16/21 at 9:58am revealed:	D 113		

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D 113	Continued From page 4 -There was always a problem with the hot water not getting hot enough. -Some days, there was no hot water, or you had to let the hot water run for a long time. -There were a couple of days (two weeks ago) when there was no hot water at all. -If she tried to use the hot water after the breakfast meal then there was no hot water for her shower. -She thought the water was cold because her room was the last room on the hallway and by the time the hot water traveled through the entire facility, hot water was cold when it reached her room. Based on calibration of the surveyor's thermometer on 11/16/21 at 11:30am revealed: -The thermometer calibrated at 34 degrees F. -To obtain a correct temperature, 2 points had to be deducted from calibrated thermometer results. Interview with the Maintenance Director on 11/16/21 at 11:15am revealed he had turned the two working hot water heaters up to 170 degrees F to try and compensate for the two water heaters that were not working. A second recheck of the hot water temperature in room D16 on 11/17/21 at 3:27pm revealed: -The hot water at the sink had to run for 5 minutes and reached a temperature of 80 degrees F. -After turning on the shower and the sink both in room D16 at the same time and running for 5 more minutes the hot water temperature reached 100 degrees F. A second recheck of the hot water temperature at the sink in room D9 on 11/16/21 at 3:20pm revealed the hot water temperature reached 102	D 113		

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D 113	Continued From page 5 degrees F after running for a few minutes. Interview with a second shift personal care aide (PCA) on 11/17/21 at 3:50pm revealed: -She had worked at the facility for three months and there had been problems with the hot water ever since she started working at the facility. -Last Friday, (11/12/21) the hot water was turned off for six hours, which was the fourth time the hot water had been turned off since she started working at the facility. -When the hot water was too cold, she gave residents a sponge bath. -Some residents had refused showers/baths because the hot water was not warm enough. -She had been told the problem with the hot water was because there was a leak in the water pipes. -Last week she noticed there was a puddle of water in the hallway by the common bath/shower room on the A hall. Refer to interview with the Maintenance Director on 11/16/21 at 10:54am. Refer to interview with the Maintenance Director on 11/16/21 at 11:15am. Refer to interview with the contacted plumber on 10/17/21 at 12:00pm. Refer to interview with the Administrator on 11/17/21 at 3:25pm. 3. Observation of resident room C6 on the C hall on 11/16/21 at 10:44am revealed: -One resident resided in room C6. -There was a bathroom with a shower attached to room C6 that was not shared. -The hot water temperature at the bathroom sink was 90 degrees F after running the water for 5	D 113		

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D 113	Continued From page 6 minutes. Based on observation and attempted interview with the resident in room C6 it was determined he was not interviewable. Observation of the Special Care Unit (SCU) common bathroom on 11/16/21 at 10:51am revealed that after running the water for several minutes the temperature fluctuated between 80 degrees F and 86 degrees F. Interview with the Maintenance Director on 11/16/21 at 11:15am revealed he had turned the two working hot water heaters up to 170 degrees F to try and compensate for the two water heaters that were not working. A second recheck of the hot water temperature at the sink in room C6 on 11/16/21 at 12:30pm revealed the hot water temperature fluctuated between 102 degrees F to 112 degrees F. A third recheck of the hot water temperature at the sink in room C6 on 11/16/21 at 3:20pm revealed the water temperature fluctuated between 100 degrees F and 110 degrees F. A second recheck of the hot water temperature in the SCU common bathroom sink on 11/16/21 at 12:33pm revealed the water temperature was 112 degrees F. A third recheck of the hot water temperature in the SCU bathroom sink on 11/16/21 at 3:25pm revealed the water temperature was 104 degrees F. Interview with a personal care aide (PCA) in the SCU on 11/16/21 at 10:44am revealed:	D 113		

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D 113	Continued From page 7 -He was agency staff and had been working at the facility six days a week. -In the mornings he needed to run the bathroom sink, the shower, and flush the toilet a couple of times before he could get warm water from the faucets. -At one point, there had been someone at the facility to fix the hot water heaters, but he did not notice any difference in the water temperatures afterwards. -With the weather in the mornings being cooler in temperature lately, it had taken longer for the hot water to heat up than it did in the summer. Review of the facility's water temperature log revealed: -There was entry by the Maintenance Director for October 19, 2021 that read "b hall to high bad mixing valve, a hall 110f d hall 122f c hall 118f". -There were no other water temperature logs provided. Review of the contracted plumber's invoice revealed: -There was a quote on 11/01/21 to shut the hot water down for 6-8 hours and replace piping in a section of the ceiling. -There was a second quote on 11/01/21 to repair 13 leaks throughout the hot water system in the mechanical room. -These leaks had to be repaired before the water heaters could have been repaired. -The expected time for all repairs to be completed was 3 weeks. Refer to interview with the Maintenance Director on 11/16/21 at 10:54am. Refer to interview with the Maintenance Director on 11/16/21 at 11:15am.	D 113		

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D 113	Continued From page 8 Refer to interview with the contacted plumber on 10/17/21 at 12:00pm. Refer to interview with the Administrator on 11/17/21 at 3:25pm. Interview with the Maintenance Director on 11/16/21 at 10:54am revealed: -The facility had four water heaters but two have not worked properly for about two weeks. -He had spoken to the contractor one week prior and the contractor was waiting on a specific part to be mailed from the manufacturer. -Two water heaters were not enough to supply the entire building with hot water especially when the kitchen and laundry were in use. -He did not know the hot water temperature was too cold this morning. Interview with the Maintenance Director on 11/16/21 at 11:15am revealed: -He had a call out to the plumber today (11/16/21) to come and service the water heaters. -He had turned the two working water heaters up to 170 degrees F to assist with increasing the hot water temperatures. -He would monitor the hot water to ensure the hot water did not get over 116 degrees F at the fixtures throughout the facility. Interview with the contacted plumber on 10/17/21 at 12:00pm revealed: -He had replaced part of the facility's plumbing 2 weeks ago. -The facility had 4 gas hot water heaters, looped together to supply the building. -He was still working on the facility's hot water heaters. -Three of the hot water heaters were working last	D 113		

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D 113	Continued From page 9 week, but one of the hot water's controller was not functioning yesterday (11/16/21) and today (11/17/21). -He was in contact with the controller representative to reset the controller parameters at present. -The facility's fourth hot water heater had parts ordered to get it operating again, which served as a backup. -Adjusting the hot water temperatures up on the 2 water heaters would help correct the low hot water temperatures because the facility had a new hot/cold water mixing valve installed a few weeks earlier. -He had the hot water temperature goal of 108 degrees F currently working for the facility. Interview with the Administrator on 11/17/21 at 3:25pm revealed: -Two of four hot water heaters that service the facility stopped working about a week and a half ago. -The contracted plumber came on 11/01/21 and fixed pipe leaks in the hall and over the four hot water heaters. -The plumber had to wait for parts to finish repair work on the two malfunctioning ht water heaters. -The Maintenance Director kept hot water temperature logs in the computer system, but he did not know the range of temperature checks and dates. -The Maintenance Director increased the temperature level on the two functioning hot water heaters on 11/16/21 to supply hot water to all areas of the facility until the two malfunctioning hot water heaters were fixed.	D 113		
D 273	10A NCAC 13F .0902(b) Health Care	D 273		

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D 273	Continued From page 10 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure referral and follow-up with health care providers for 2 of 5 sampled residents (#1 and #5) regarding a home health referral (#1) and an order for compression stockings (#4). The findings are: 1. Review of Resident #1's current FL2 dated 06/16/21 revealed diagnoses included ST (S and T wave segments on an electrocardiogram) elevation myocardial infarction (STEMI) (a heart attack caused by an artery being 100% blocked). Review of Resident #1's previous FL2 dated 01/21/21 revealed diagnoses included Alzheimer's dementia, hypertension, and diabetes. Review of Resident #1's hospital discharge summary dated 06/16/21 revealed an order for home health services to include skilled nursing, physical therapy (PT) and occupational therapy (OT). Review of the home health notes section in Resident #1's record on 11/17/21 at 1:00pm revealed there were no evaluations or progress notes from home health. Interview with the Resident Care Coordinator (RCC) on 11/17/21 at 1:25pm revealed: -The person who was responsible for following up on hospital discharge orders had been the nurse	D 273	ED completed training for Supervisors and Med Managers on 12/13/21 on meeting health care needs of the residents. Referrals for 3rd party providers will be communicated when received with follow up to ensure services are initiated timely and as ordered.	12/31/21

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D 273	Continued From page 11 up until she quit her job on 10/29/21. The RCC was now responsible for following through on new orders. -She thought the nurse had been doing record audits to reconcile new orders every 6 months. -She was now responsible to complete audits on the new physician orders versus the medication administration record (MAR) whenever she got a chance, as she was also working many shifts as a medication aide (MA). Interview with Resident #1's primary care provider (PCP) on 11/17/21 at 1:45pm revealed: -She did not write the order for a referral to home health, but she would not have discontinued the order either. -She would have liked Resident #1 to receive home health services as she felt the more healthcare staff available to residents, the more they benefited in general. -She had not been notified that the referral was not followed up on. Telephone interview with Resident #1's responsible person on 11/17/21 at 2:20pm revealed she was unaware of a referral to home health services when Resident #1 was discharged from the hospital. Interview with the Administrator on 11/17/21 at 2:30pm revealed: -He was unaware that Resident #1 had a referral to home health that had not been followed up on. -It was the nurse's responsibility to review new physician orders and do record audits to ensure orders were not missed. The nurse who had been employed at the time of Resident #1's home health referral in June was no longer working there. -Until a new nurse was hired, it was the RCC's	D 273		

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D 273	Continued From page 12 responsibility to follow up on new physician orders. Telephone interview with a representative from the home health agency revealed: -They received information about the referral for Resident #1 in June 2021 but were unable to see her due to being out of her insurance network. -The facility was aware that they were unable to see Resident #1 for home health services. Interview with the Special Care Unit Coordinator (SCUC) on 11/17/21 at 3:00pm revealed: -She was unaware if Resident #1 ever received home health services. -It was not her responsibility to review resident records for new orders. Interview with the contracted physical therapist on 11/17/21 at 3:36pm revealed: -Her company leased an office space inside the facility. -They had done a PT evaluation on Resident #1 in the past, but it was before her home health referral on 06/16/21. -She provided names of two other home health agencies in the area that might have received Resident #1's referral on 06/16/21. Telephone interview with a representative from a second home health agency on 11/17/21 at 3:45pm revealed they had not received a referral for home health for Resident #1. Telephone interview with a representative from a third home health agency on 11/17/21 at 3:50pm revealed they had not received a referral for home health for Resident #1. Based on observation, record review and	D 273		

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D 273	Continued From page 13 interview, it was determined that Resident #1 was not interviewable. 2. Review of Resident #4's current FL2 dated 06/07/21 revealed diagnoses Parkinson's disease, hypertension, and osteoarthritis of the knees. Review of Resident #4's physicians' orders dated 07/27/21 revealed diagnoses included stasis dermatitis (a form of skin irritation treat with compression stockings) and an order to assist daily to zip up compression stockings. Review of Resident #4's physician's orders revealed: -There was a signed physician's orders dated 08/09/21 revealed an order for zippered TED (a type of compression hose) apply every morning and resident will remove at bedtime (family provides). -There was an order dated 10/25/21 for compression stocking's knee high 20 millimeters of mercury (20 mm hg use to measure amount of compression) There was an addendum must be toeless and velcro wrap closure. Observations of Resident #4 on 11/16/21 revealed: -At 10:45am, Resident #4 was not wearing velcro compression hose. -At 4:45pm, Resident #4 was lying in bed with pant legs exposing legs to the shins with slight edema in both lower left and right legs with the lower right leg more edematous (ankles still easily visible) and no compression stockings were on the resident's legs. Observation of Resident #4 on 11/17/21 at 11:10am revealed Resident #4 was seated in her	D 273		

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D 273	Continued From page 14 room and was not wearing velcro compression hose. Review of Resident #4's September 2021 and October 2021 electronic medication administration records (eMARs) revealed: -There was an entry for zippered TED hose-apply every morning and resident will remove at bedtime scheduled at for 8:00am with documentation of administration daily from 09/01/21 to 10/31/21. Review of Resident #4's November 2021 eMAR revealed: -There was an entry for zippered TED hose-apply every morning and resident will remove at bedtime scheduled at for 8:00am with documentation of administration daily from 10/01/21 to 10/12/21. -There was an entry for compression stockings 20mm hg apply every morning remove at bedtime. Must be toeless with Velcro closure, scheduled for 8:00am to be put on and 8:00pm to be removed. -On 11/13/21, 11/15/21, and 11/16/21 at 8:00am application of the stockings was documented. Interview with Resident #4 on 11/17/21 at 11:25am revealed: -She was wearing black 20mm hg knee high open toe compression stocking because she her second toe crossed over the great toe and the pressure from socks was uncomfortable; her legs swelled when she got up in the mornings, particularly the right leg, and the compression stockings seemed to help with the swelling. -She originally was ordered a compression stocking with zippers in order for her to be able to remove them more easily due to arthritis in her hands.	D 273		

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D 273	Continued From page 15 -The personal care aides (PCAs) applied the zippered compression hose in the morning until about a month ago, but the swelling was worse and PCAs were having a hard time zipping the hose. -She went to her physician's office (her family member took her) on 09/25/21 to discuss another type of compression hose and swollen legs. -The primary care provider (PCP) ordered knee high compression stocking, open toes, and for the resident to try open toes for comfort. -She and her family member went to the medical equipment (ME) supplier suggested by the PCP on the following Saturday for fitting and to get the velcro compression stockings. -She returned to the facility with the velcro stockings, but the facility staff was not familiar with Velcro closure stocking and would not apply the velcro compression stockings. -She called her PCP to get an order for the velcro wrap compression stockings to be faxed to the facility for the staff to receive training on applying the hose. -Last Saturday (11/14/21), she and her family member went back to the ME supplier to get a pair of open toes 20mm hg compression stockings that were not velcro closure so staff could assist with applying the hose to help with her swelling legs. Telephone interview with an office assistant at Resident #4's PCP's revealed: -On 09/25/21, there was documentation Resident #4 was seen in the office for compression hose and an order for 20mm hg knee high compression hose was given. -On 10/22/21, Resident #4 contacted the office regarding the physician's order not having Velcro closures on the order. -There was no documentation the facility	D 273		

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D 273	Continued From page 16 contacted the PCP's office regarding compression stockings not being applied to Resident #4. -On 11/12/21, Resident #4 contacted the PCP's office requesting the PCP send an order to the facility for the Velcro closure compression stockings so the facility could provide training on the application of the stockings to Resident #4. -On 11/12/21, the PCP sent an order to the facility's Resident Care Coordinator (RCC) for Resident #4's compression stockings with Velcro closure. -On 11/15/21, Resident #4 left a message with the PCP's office Triage Nurse regarding worsening edema in her right leg and Velcro compression stockings were not applied. An appointment was scheduled for 11/16/21, but canceled by the resident and rescheduled for 11/18/21. -There was no documentation the facility contacted the PCP's office for notification Resident #4 had increased swelling, or that she was not receiving Velcro closure stockings application as ordered. Interview with the RCC on 11/17/21 at 2:15pm revealed: -The medication aide (MA) should inform the shift Supervisor if a medication or treatment was not completed as ordered. -The Supervisor or the RCC should inform the PCP if the treatment or medication was not administered as ordered. -Resident #4 and her family member were very active in coordinating the resident's health care. -Resident #4 scheduled most of her own appointments and transportation to the appointments. -She had not been trained on the correct application of Resident #4's Velcro closure	D 273		

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D 273	Continued From page 17 stockings or arranged for other staff to be trained. -She had not contacted Resident #4's PCP regarding the resident not having compression stockings applied as ordered. Interview with the Administrator on 11/17/21 at 2:18pm revealed the RCC or Supervisors were responsible to ensure orders for treatments were completed and to notify the residents' PCP if an order was not completed.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record review the facility failed to ensure physician's orders were implemented for 1 of 5 sampled residents (Resident #1) related to an order for a urine sample to rule out infection. The findings are: Review of Resident #1's current FL2 dated 06/16/21 revealed diagnoses included ST (S and T wave segments on an electrocardiogram) elevation myocardial infarction (STEMI) (a heart attack caused by an artery being 100% blocked). Review of Resident #1's previous FL2 dated	D 276	Resident Care Coordinator and/or designee will ensure Physician orders are followed to meet resident health care needs. ED completed training on 12/13/21 with shift Supervisors and Med Techs that receive orders, to ensure timely responsiveness and communication is made with the lab as appropriate. The RCC and/or designee will monitor physician orders on a daily basis.	12/31/21

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D 276	Continued From page 18 01/21/21 revealed diagnoses included Alzheimer's dementia, hypertension, and diabetes. Review of Resident #1's physician's order dated 09/02/21 revealed there was an order for staff to collect a urine sample to check for infection. Review of Resident #1's laboratory results revealed there was no urinalysis (UA) result from 09/01/21 to 11/17/21. Telephone interview with a representative from the facility's contracted laboratory on 11/17/21 at 11:15am revealed: -The process for lab orders was that the facility would collect the lab specimen and then call the laboratory to pick up the specimen along with a copy of the lab order. -They did not receive a urine specimen or a UA order for Resident #1 in September 2021. Interview with the Resident Care Coordinator (RCC) on 11/17/21 at 1:25pm revealed: -The person who was responsible for following up new physician orders had been the nurse up until she quit her job on 10/29/21. The RCC was now responsible for following through on new orders. -She thought the nurse had been doing record audits to reconcile new orders every 6 months. -She was now responsible for completing the chart audits to reconcile new physician orders whenever she got a chance, as she was also working many shifts as a medication aide (MA). -The order for the UA should not have been filed in Resident #1' record until the lab specimen was collected. Telephone interview with Resident #1's primary care physician (PCP) on 11/17/21 at 1:45pm	D 276		

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D 276	Continued From page 19 revealed: -She had ordered the UA as Resident #1 was having symptoms of increased urinary incontinence. -She had not been notified that the facility did not or was unable to collect the urine specimen. -She would except the facility to follow up with her if they were unable to collect the urine specimen as ordered. -The potential harm to Resident #1 for not having her urine checked for infection was that if an infection had been present, it could have either spread or caused worsening symptoms or increased confusion. -She assumed that since the facility had not contacted her to report worsening symptoms, Resident #1's symptoms had improved or resolved. Interview with the Administrator on 11/17/21 at 2:30pm revealed: -He was not aware that Resident #1 had a lab order for a UA that had not been completed. -It was the nurse's responsibility to review new physician orders and do chart audits to ensure orders were not missed. The nurse who had been employed at the time of Resident #1's UA order in September was no longer working there. -Until a new nurse was hired, it was the RCC's responsibility to follow up on new physician orders. Interview with the Special Care Unit Coordinator (SCUC) on 11/17/21 at 3:00pm revealed: -She was unaware of Resident #1 ever having an order for staff to collect a urine specimen on 09/02/21. -It was not her responsibility to review resident records for new orders.	D 276		

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D 276	Continued From page 20 Interview with a personal care aide (PCA) on 11/17/21 at 4:00pm revealed: -She had not been aware of a UA order for Resident #1 in September 2021. -The MA was responsible for collecting lab specimens and contacting the lab to collect them when ready. -They did not notice any new or worsening urinary incontinence or increased confusion for Resident #1 at the present time. Based on observations, record reviews and interviews, it was determined Resident #1 was not interviewable.	D 276		
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: Based on observations, record reviews, and interviews the facility failed to ensure clarification of medication orders for 1 of 5 sampled residents (#1) who had orders for a diabetic medication to	D 344	RCC and/or designee will communicate with the Prescriber for immediate verification/clarification of orders when changes are made to either medication or treatment plan. RCC and/or designee will monitor ongoing for compliance	12/31/21

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D 344	Continued From page 21 control blood sugar, a thyroid medication, a blood pressure medication, a supplement, and a pain medication. The findings are: Review of Resident #1's previous FL2 dated 01/21/21 revealed: -Diagnoses included Alzheimer's dementia, hypertension, and diabetes. -There were medication orders for lisinopril (a medication to help treat high blood pressure) 10mg daily, levothyroxine (a medication used to treat hypothyroidism) 88mcg daily, glimepiride (a medication used to control blood sugars in people who have diabetes) 4mg daily, Vitamin D3 5,000mg daily, Equate for arthritis pain formula 650mg daily. Review Resident #1's current FL2 and hospital discharge summary dated 06/16/21 revealed: -Diagnoses included ST (S and T wave segments on an electrocardiogram) elevation myocardial infarction (STEMI) (a heart attack caused by an artery being 100% blocked). -There was an order to stop taking lisinopril 10mg. -There was an order to continue taking glimepiride 4mg every morning before breakfast. -There was an order to continue taking levothyroxine 88mcg daily. -There was an order to continue taking cholecalciferol (a vitamin D3 supplement) 50mcg (2,000 unit), three capsules once daily. Review of Resident #1's physician signed progress note dated 07/15/21 revealed there was a list of current medications which included notes as follows: glimepiride 2mg daily with breakfast (note: decreasing dose as starting metformin to	D 344		

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D 344	Continued From page 22 avoid hypoglycemia), levothyroxine 75mcg every morning on an empty stomach (note: decreasing her dose), cholecalciferol 125mcg (5,000 units) 1 capsule daily, and acetaminophen extended release (ER) 650mg once daily. Review of Resident #1's signed Physician Orders dated 08/05/21 revealed: -There was an order for glimepiride 4mg tablet, take 1 tablet every morning before breakfast at 7:30am. -There was an order for levothyroxine 88mcg tablet, take 1 tablet once daily at 6:00am. -There was an order for Vitamin D3 50mcg (5,000 unit) tablets, take 3 tablets once daily at 8:00am. -There were no orders for lisinopril or acetaminophen. Review of Resident #1's physician signed progress note dated 09/02/21 revealed there was a list of current medications which included notes as follows: glimepiride 2mg daily with breakfast (note: decreasing dose as starting metformin to avoid hypoglycemia), levothyroxine 75mcg every morning on an empty stomach (note: decreasing her dose), cholecalciferol 125mcg (5,000 units) 1 capsule daily, and acetaminophen extended release (ER) 650mg once daily. Review of Resident #1's electronic medication administration record (eMAR) from September 2021, October 2021, and November 2021 revealed: -There was an entry for glimepiride 4mg tablet, take 1 tablet every morning before breakfast at 7:30am. -There was an entry for levothyroxine 88mcg tablet, take 1 tablet once daily at 6:00am. -There was an entry for Vitamin D3 50mcg (2,000 units) take 3 tablets (6,000 units) once daily at	D 344		

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D 344	Continued From page 23 8:00am. -There were no entries for lisinopril or acetaminophen on the eMARs. Telephone interview with a representative from the facility's contracted pharmacy on 11/16/21 at 4:50pm revealed: -The order they had on file for glimepiride was to take 4mg daily; there was a previous order for 2mg daily, but it was discontinued on 06/16/21 and changed to 4mg daily. -The order they had on file for levothyroxine was for 88mcg daily; there was a previous order for 75mcg daily, but it was discontinued on 06/16/21 and changed to 88mcg daily. -The order the pharmacy had on file for Vitamin D3 was to take a total of 6,000 units (3 capsules) daily; there was a previous order for just 1 capsule per day, but it was discontinued on 06/1621 and changed to 3 capsules daily. -They did not have any current orders on file for lisinopril or acetaminophen. Telephone interview with Resident #1's primary care provider (PCP) on 11/17/21 at 9:30am revealed: -She did not know what dosage of glimepiride, levothyroxine or Vitamin D3 Resident #1 should be taking, or if she had wanted her to resume taking lisinopril and acetaminophen, as she could not verify if the dosages listed on the progress notes were changed before or after Resident #1's hospital discharge on 06/16/21. -It was her expectation that staff from the facility contacted her for clarification if the list of current medications on the progress notes did not match what was listed on the eMAR. -She planned to review Resident #1's medications when she went to the facility the following day (11/18/21).	D 344		

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D 344	Continued From page 24 Interview with the Resident Care Coordinator (RCC) on 11/17/21 at 1:25pm revealed: -The person who was responsible for following up on new physician orders had been the nurse up until she quit her job on 10/29/21. The RCC was now responsible for following up on new orders. -She thought the nurse had been doing record audits to reconcile new orders every 6 months. -She was now responsible for completing the record audits to reconcile new physician orders whenever she got a chance, as she was also working many shifts as a medication aide (MA). Interview with the Administrator on 11/17/21 at 2:30pm revealed: -It was the nurse's responsibility to review new physician orders and do chart audits to ensure orders were not missed. The nurse who had been employed at the time of Resident #1's hospital discharge and subsequent physician progress notes was no longer employed there as of 10/29/21. -Until a new nurse was hired, it was the RCC's responsibility to follow up on new physician orders or clarify orders. -It was his expectation that MA staff contact the PCP for clarification on any orders that do not match the current eMAR or most recent signed physician order sheet. Interview with the SCUC on 11/17/21 at 3:00pm revealed it was not her responsibility to review resident records for new medication orders or to do record audits.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	Continued From page 25 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a physician for 1 of 5 sampled residents (#1) related to diabetic medications. The findings are: Review of Resident #1's current FL2 dated 06/16/21 revealed diagnoses included ST (S and T wave segments on an electrocardiogram) elevation myocardial infarction (STEMI) (a heart attack caused by an artery being 100% blocked). Review of Resident #1's previous FL2 dated 01/21/21 revealed diagnoses included Alzheimer's dementia and diabetes. Observation of medication pass on 11/17/21 at 8:15am revealed: -The medication aide (MA) administered glimepiride and metformin to Resident #1. -Resident #1 had already eaten breakfast. -The remaining 29 medications were administered as ordered for a medication pass error rate of 6%. Review of Resident #1's signed Physician Orders dated 08/05/21 revealed:	D 358	ED provided training for shift Supervisors and Med Techs on 12/13/21 to ensure medication administration is followed as prescribed by PCP. Training topics included Narcotic count and ordering medication ordering, and communication with prescribing Practitioner. RCC and/or designee will monitor medication administration routinely by conducting emar audits on a monthly basis.	12/31/21

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D 358	Continued From page 26 -There was an order to check and record fingerstick blood sugar (FSBS) every morning before medications, hold glimepiride and metformin if less than 100, at 7:00am. -There was an order for glimepiride 4mg tablet, take 1 tablet every morning before breakfast at 7:30am. -There was an order for metformin 500mg tablet, take 1 tablet every morning with meals at 8:00am. Review of Resident #1's October 2021 electronic medication administration record (eMAR) revealed: -There was an entry to check and record blood sugar every morning before medications, hold glimepiride and metformin if less than 100, at 7:00am. -There was an entry for glimepiride 4mg tablet take 1 tablet every morning before breakfast at 7:30am. -There was an entry for metformin 500mg tablet take 1 tablet every morning with meals at 8:00am. -On 10/21/21 Resident #1's fingerstick blood sugar (FSBS) was 94. -On 10/21/21 there was documentation that glimepiride was held, but metformin was administered. Review of Resident #1's November 2021 eMAR revealed: -There was an entry to check and record blood sugar every morning before medications, hold glimepiride and metformin if less than 100, at 7:00am. -There was an entry for glimepiride 4mg tablet take 1 tablet every morning before breakfast at 7:30am. -There was an entry for metformin 500mg tablet take 1 tablet every morning with meals at 8:00am. -There was documentation that Resident #1's	D 358		

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	HAL068035	A. BUILDING: _____ B. WING _____	11/17/2021

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D 358	Continued From page 27 FSBS was over 100 every morning up to 11/17/21, with glimepiride and metformin administered as ordered. -On 11/17/21 glimepiride and metformin were administered and there was no FSBS recorded on the eMAR. Interview with the medication aide (MA) on 11/17/21 at 8:25am revealed: -When she was asked what Resident #1's FSBS was for that morning, she reviewed the eMAR for the 7:00am FSBS reading and there was no FSBS recorded for that morning. -Usually if an FSBS was not completed or if the FSBS was less than 100, there would be a pop-up on the eMAR to indicate not to administer the glimepiride or metformin. -At 8:30am she checked Resident #1's FSBS and got a FSBS reading of 187. -The MA staff would check what Resident #1's FSBS was prior to administering medications, but that morning she had forgotten to. Interview with Resident #1's primary care physician (PCP) on 11/17/21 at 9:30am revealed: -It was her expectation that MA staff would always check Resident #1's FSBS before administering any diabetic medications. -The potential harm to Resident #1 that could result from administering glimepiride and metformin before checking her FSBS was hypoglycemia (a drop in blood sugar could cause fatigue, lightheadedness, confusion, shakiness, blurred vision, heart palpitations, unsteadiness, among other symptoms). Interview with the Administrator on 11/17/21 at 2:30pm revealed it was his expectation that MA staff administer medications as ordered or notify him of any errors.	D 358		

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D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medication aides observed residents taking their medication for 1 of 5 sampled resident (#4) related to observation of the resident with medications left in a cup on 11/16/21. The findings are: Review of Resident #4's current FL2 dated 06/07/21 revealed diagnoses Parkinson's disease, hypertension, hypercholesterolemia, and osteoarthritis of the knees. Review of Resident #4's current FL2 dated 06/07/21, and signed physicians' orders dated 08/09/21 revealed medication orders as follows: -There was an order for Zetia (used to treat hypercholesterolemia) 10mg daily. -There was an order for Sinemet (used to treat tremble from Parkinson's Disease) 25-100mg at 7:30am, and 10:00am; take 1/2 tablet at 12:00pm, 4:00pm, 6:00pm and 8:00pm daily. -There was an order for aspirin (used to improve circulation) 81mg daily.	D 366	RCC and/or designee to observe weekly med pass observations times 4 weeks and quarterly thereafter for compliance.ED and/or designee will complete random audits during med pass for compliance.	12/31/21

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D 366	Continued From page 29 -There was an order for vitamin (a supplement for vitamin) C 1000mg daily. -There was an order for zinc (a mineral supplement) 50mg daily. -There was an order for calcium (a mineral supplement for bone mass) 600mg one daily. -There was an order for vitamin (a vitamin supplement) E 180mg one daily. -There was an order for vitamin (a vitamin supplement) D3 2000 international units daily. -There was an order for multivitamin (a vitamin supplement) one daily. Observation of Resident #4's room on 11/16/21 at 9:48am, during the initial facility tour, revealed: -Resident #4 was in her room and there was a night stand located next to her bed. -On top of the night stand was a paper souflee cup with 9 oral medications and an opened plastic single serving cup of applesauce. -There was another white paper souflee cup with 6 pieces of one-half tablets in the cup. Interview with Resident #4 on 09/16/21 at 9:50am revealed: -The medication aide (MA) that brought the morning medications to her room (around 8:00am) told her she was working the both the Special Care Unit medication cart and the medication cart for her hall. -Resident #4 was preparing to go to a doctor's appointment later in the day and told the MA she could sit the medications on the night stand and she would take them in a little bit. -She also needed some of her Sinemet 25-100 tablets that she took one-half tablet at extra times between her morning and evening medications because she had a doctor's appointment that her family member was supposed to take her today (11/16/21).	D 366		

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D 366	Continued From page 30 -She had been taking Sinemet for her Parkinson's for a long time did not want to miss those doses. Review of Resident #4's electronic medication administration record (eMAR) for November 2021 revealed: -There was an entry for aspirin 81mg daily scheduled for administration at 8:00am and documented as administered at 8:00am on 11/16/21. -There was an entry for vitamin C 1000mg daily scheduled for administration at 8:00am and documented as administered at 8:00am on 11/16/21. -There was an order for zinc 50mg daily scheduled for administration at 8:00am and documented as administered at 8:00am on 11/16/21. -There was an order for calcium 600mg one daily scheduled for administration at 8:00am and documented as administered at 8:00am on 11/16/21. -There was an order for vitamin E 180mg one daily scheduled for administration at 8:00am and documented as administered at 8:00am on 11/16/21. -There was an order for vitamin D3 2000 international units daily scheduled for administration at 8:00am and documented as administered at 8:00am on 11/16/21. -There was an order for multivitamin one daily scheduled for administration at 8:00am and documented as administered at 8:00am on 11/16/21. Interview with the medication aide (MA) administering medications for Resident #4 on 11/16/21 at 3:00pm revealed: -She was running behind on medication administration this morning.	D 366		

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D 366	Continued From page 31 -She thought she brought Resident #4's medications in the dining room at breakfast and walked away. -She did not watch Resident #4 take the medications before she walked away. -Resident #4 must have brought the medications back to her room to take herself. -The MA knew she was supposed to prepare medications, administer the medications including watching the resident take the medication before documenting administration on the eMAR. -She was in a hurry and did not stay to watch Resident #4 swallow the medications. Second interview with Resident #4 on 11/17/21 at 11:55am revealed: -MAs routinely brought her morning medications to her room after breakfast. -Occasionally she was given her morning medications in the dining room but not often. -She used applesauce to take medications because it made swallowing the big tablets easier. Interview with the Administrator on 11/17/21 at 2:15pm revealed MAs were supposed to prepare medications, administer medications including watching the resident swallow the medications, and document administration on the eMAR prior to moving to the next resident.	D 366		