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D 000	Initial Comments The Adult Care Licensure Section and the Bertie County Department of Social Services conducted an annual survey on 10/27/21-10/28/21.	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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up for 2 of 3 sampled residents related to blood sugars outside of ordered parameters and notification to the primary care provider (#3) and a required follow-up appointment after a hospital visit (#1). The findings are: 1.Review of Resident #3's current FL-2 dated 06/14/21 revealed: -Diagnoses included diabetes mellitus type 2 (DM), chronic obstructive pulmonary disease (COPD) with exacerbations, acute kidney injury, and hyperkalemia (increased potassium levels in the blood). -She was intermittently disoriented, semi-ambulatory, and used a walker. -There was an order for Novolog 100u/ml, give 5units (u)(insulin, used to lower blood sugar) three times daily with meals. Review of blood sugar standing orders for Resident #3 dated 01/13/21 revealed:	D 273		

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-If blood sugars are below 60, give orange juice with sugar in it immediately and give resident a sandwich, peanut butter crackers, or other protein/complex carbohydrate food.
-Recheck the blood sugar in 30-minutes.
-If recheck of blood sugar is still below 60 and resident is awake, give more orange juice with sugar or non-diet soda.
-Recheck the blood sugar again in 30-minutes.
-If blood sugar remains below 60, send the resident to the emergency department (ED).

Review of Resident #3's August 2021 electronic medication administration records (eMAR) revealed:
-There was an entry for Novolog 100u/ml, give 5 units three times daily with meals at 8:00am, 12:00pm, and 6:00pm for DM with blood sugar checks.
-There were 6 of 93 opportunities in August 2021 the resident's blood sugars were below 60, when Novolog was administered, and there were no interventions per the standing orders.
-On 08/05/21 at 12:00pm, her blood sugar was 59, the Novolog 5 units was administered despite the blood sugar being less than 60, and there were no interventions or blood sugar rechecks documented per the standing orders.
-On 08/08/21 at 6:00pm, her blood sugar was 55, the Novolog 5 units was administered despite the blood sugar being less than 60, and there were no interventions or blood sugar rechecks documented per the standing orders.
-On 08/17/21 at 8:00am, her blood sugar was 9, the Novolog 5 units was administered despite the blood sugar being less than 60, and there were no interventions or blood sugar rechecks documented per the standing orders.
-On 08/19/21 at 12:00pm, her blood sugar was 53, the Novolog 5 units was administered despite

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the blood sugar being less than 60, and there were no interventions or blood sugar rechecks documented per the standing orders.
-On 08/20/21 at 12:00pm, her blood sugar was 42, the Novolog 5 units was administered despite the blood sugar being less than 60, and there were no interventions or blood sugar rechecks documented per the standing orders.
-On 08/31/21 at 12:00pm, her blood sugar was 58, the Novolog 5 units was administered despite the blood sugar being less than 60, and there were no interventions or blood sugar rechecks documented per the standing orders.

Review of Resident #3's September 2021 eMAR revealed:
-There was an entry for Novolog 100u/ml, give 5 units three times daily with meals at 8:00am, 12:00pm, and 6:00pm for DM with blood sugar checks.
-There were 4 of 90 opportunities in September 2021 the resident's blood sugars were below 60 or not documented, the Novolog was still administered, and there were no interventions to more closely monitor or bring the resident's blood sugar back up above 60.
-On 09/05/21 at 12:00pm, her blood sugar was 57, the Novolog 5 units was administered despite the blood sugar being less than 60, and there were no interventions or blood sugar rechecks documented per the standing orders.
-On 09/06/21 at 6:00pm, her blood sugar was 49, the Novolog 5 units was administered despite the blood sugar being less than 60, and there were no interventions or blood sugar rechecks documented per the standing orders.
-On 09/10/21 at 12:00pm, her blood sugar was , the Novolog 5 units was administered despite the blood sugar being less than 60, and there were

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no interventions or blood sugar rechecks documented per the standing orders.
-On 09/10/21 at 6:00pm, her blood sugar was not documented , the Novolog 5 units was administered despite the blood sugar not being documented, and there were no interventions or blood sugar rechecks documented.

Review of Resident #3's October 2021 eMAR revealed:
-There was an entry for Novolog 100u/ml, give 5 units three times daily with meals at 8:00am, 12:00pm, and 6:00pm for DM with blood sugar checks.
-There were 7 of 79 opportunities in October 2021 the resident's blood sugars were below 60, the Novolog was still administered, and there were no interventions to more closely monitor or bring the resident's blood sugar back up above 60.
-On 10/02/21 at 12:00pm, her blood sugar was 56, the Novolog 5 units was administered despite the blood sugar being less than 60, and there were no interventions or blood sugar rechecks documented per the standing orders.
-On 10/03/21 at 12:00pm, her blood sugar was 50, the Novolog 5 units was administered despite the blood sugar being less than 60, and there were no interventions or blood sugar rechecks documented per the standing orders.
-On 10/07/21 at 6:00pm, her blood sugar was 44, the Novolog 5 units was administered despite the blood sugar being less than 60, and there were no interventions or blood sugar rechecks documented per the standing orders.
-On 10/09/21 at 6:00pm, her blood sugar was 50, the Novolog 5 units was administered despite the blood sugar being less than 60, and there were no interventions or blood sugar rechecks documented per the standing orders.

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-On 10/15/21 at 6:00pm, her blood sugar was 51, the Novolog 5 units was administered despite the blood sugar being less than 60, and there were no interventions or blood sugar rechecks documented per the standing orders.
-On 10/17/21 at 6:00pm, her blood sugar was 48, the Novolog 5 units was administered despite the blood sugar being less than 60, and there were no interventions or blood sugar rechecks documented per the standing orders.
-On 10/24/21 at 6:00pm, her blood sugar was 40, the Novolog 5 units was administered despite the blood sugar being less than 60, and there were no interventions or blood sugar rechecks documented per the standing orders.

Interview with Resident #3 on 10/27/21 at 3:00pm revealed she was unaware she had any issues with her blood sugars falling below 60.

Interview with a medication aide (MA) on 10/27/21 at 3:03pm revealed:
-She usually checked Resident #3's blood sugar and administered insulin three times per day.
-She looked to make sure the blood sugar was not too low, less than 60, before administering insulin.
-If Resident #3's blood sugar was less than 60, she would hold the resident's insulin to keep the blood sugar from dropping further.

Interview with a second MA on 10/28/21 at 2:24pm revealed:
-If a resident had a blood sugar less than 60, she was supposed to give orange juice to the resident then re-check the blood sugar in two hours per facility policy.
-Resident #3 had low blood sugars approximately every other day requiring interventions such as

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giving organge juice and rechecking the blood sugar.
-She never documented any interventions such has giving a resident orange juice or rechecking the blood sugars anywhere in a resident's chart or eMAR, she did not know why but was trained to documented interventions.
-She had seen Resident #3's standing orders before but had not thought to apply the orders to the resident's care when the resident experienced blood sugars less than 60.
-There was no way to know what interventions had been done or if Resident #3's blood sugars had come up when she experienced low blood sugars because the facility had not documented anything which meant "if it was not documented, it was not done".
-She should have followed the standing orders for Resident #3 when the resident had blood sugars less than 60 as the resident's PCP had prescribed.
-She should have called Resident #3's PCP to notify him when her blood sugars were less than 60 and to obtain an order to hold her Novolog so her sugar did not drop any lower.

Interview with the lead medication aide/supervisor (MA/S) on 10/28/21 at 2:49pm revealed:
-If Resident #3 had a low blood sugar, she would just hold the resident's insulin until after she ate.
-If she provided any interventions for Resident #3's low blood sugars, she would not have documented anywhere, she did not know why but was trainied to documented interventions for residents.
-She had never contacted Resident #3's PCP for blood sugars below 60 because the resident had never had any slurred speech and said she felt fine; the resident just needed to eat.
-When Resident #3 experienced blood sugars

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below 60, she would usually give her water because she would always say she was thirsty.
- When brought to her attention, she realized she had seen Resident #3's standing orders before, but had never followed them because Resident #3 was not symptomatic from her low blood sugars and was always getting ready to eat.
-It was the facility's policy for her to follow the standing orders for low blood sugars as written.

Interview with the Administrator on 10/28/21 at 4:14pm revealed:
-She expected the MAs to administer medications and treatments safely and as ordered.
-MAs must contact a resident's PCP prior to deviating from PCP orders for a resident.
-She was not aware Resident #3 had been experiencing blood sugars less than 60.
-She was not aware that the MAs were not following the standing orders when Resident #3 was experiencing low blood sugars less than 60.
-She expected the MAs to document interventions and contact the PCP for Resident #3 when her blood sugar was less than 60.
-She would have stopped the MAs on the spot from administering Resident #3's Novolog when her blood sugar was less than 60 to call the resident's PCP for further guidance.
-She expected the MAs to call Resident #3's PCP when she experienced blood sugar less than 60.
-She was concerned that Resident #3 had unstable and low blood sugars because it could be dangerous and lead to complications such as diabetic shock.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/28/21 at 12:10pm revealed that giving a resident insulin when the blood sugar was less than 60 could further decrease the blood sugar causing an

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increased risk of injury such as falls, confusion, shakiness, and unconsciousness.

Telephone interview with a clinical staff member at Resident #3's PCP office on 10/28/21 at 10:57am revealed:
-Resident #3's blood sugars should have been maintained above 60 per the standing order.
-If the resident's blood sugars were less than 60, it should have been reported to the PCP, would have required interventions per the standing orders, and may have required a hospital evaluation.

Telephone interview with Resident #3's PCP on 10/28/21 at 12:29pm revealed:
-He last saw Resident #3 on 10/21/21.
-He expected the facility to check the resident's blood sugar prior to administering her Novolog to make sure her blood sugars were in a safe range for insulin administration.
-If Resident #3's blood sugars were less than 60, the facility was expected to implement the standing orders of interventions and recheck blood sugars or send the resident to the hospital and notify him.
-He exptect the facility to notifiy him of Resident #3's blood sugars less than 60 to obtain an order hold the resident's Novolog to prevent her sugar from dropping any more.
-He was not aware that the resident was having blood sugars less than 60 and expected the facility to notify him so he could assess the resident and adjust her orders.
-If he had known that the resident's blood sugars were less than 60, he would have adjusted the management of her DM by discontinuing her insulin and providing orders to monitor her blood sugars more closely.
-It was concerning that he had not been made

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aware of the resident's blood sugars being below 60 and the facility had not followed the standing orders of interventions because having low blood sugars that were untreated was potentially deadly.

2. Review of Resident #1's current FL-2 dated 03/26/21 revealed:
-Diagnoses included type 2 diabetes mellitus, left lower leg amputation, hypertension, and peripheral vascular disease.
-He was incontinent of bladder and bowel.

Review of Resident #1's facility progress note dated 09/30/21 revealed:
-The resident was sent to the hospital at 7:30am on 09/30/21 for blood in his urine.
-He had very cloudy and foul-smelling urine.

Review of Resident #1's hospital discharge summary dated 09/30/21 revealed:
-Resident #1 presented to the emergency department (ED) on 09/30/21 for blood in his urine.
-Resident #1 was discharged to the facility with a diagnosis of hematuria (blood in the urine) and a 7-day course of antibiotics.
-Resident #1 was to have a follow up appointment scheduled with his primary care physician (PCP) "next week without fail".

Telephone interview with a clinical staff member at Resident #2's PCP office on 10/28/21 at 10:57am revealed:
-Resident #1 was seen by his PCP on 08/24/21 and 10/21/21.
-There was no record of Resident #1 being seen within one week of discharge from the ED on 09/30/21.
-There was no record of the facility calling to

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schedule an appointment for Resident #1 after discharge from the ED on 09/30/21.

Interview with Resident #1 on 10/28/21 at 12:30pm revealed:
-He went to the ED in September of 2021 because he noticed blood in his urine.
-He had not seen his PCP after his trip to the emergency department in September of 2021.
-The facility was responsible for scheduling his medical appointments.
-The facility was responsible for transporting him to his medical appointments.
-He was no longer having blood in his urine.

Interview with a medication aide (MA) on 10/28/21 at 2:20pm revealed:
-The lead MA/Supervisor was responsible for reviewing hospital discharge paperwork.
-The lead MA/Supervisor was responsible for scheduling medical appointments including hospital follow up appointments.

Interview with the lead MA/Supervisor on 10/28/21 at 2:50pm revealed:
-The MA that received the resident back from the hospital was responsible for reviewing their paperwork.
-She was not working when Resident #1 went to the emergency room on 09/30/21, so she did not review his discharge paperwork.
-When she returned to work, she was not aware that Resident #1 was to have a follow up appointment after the resident was discharged on 09/30/21.

Interview with the Administrator on 10/28/21 at 4:15pm revealed:
-Resident #1's hospital follow-up appointment was missed, and she was not sure how it was

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missed.
-The lead MA/Supervisor was responsible for processing discharge paperwork including scheduling follow-up appointments.
-It was her expectation that residents were scheduled for follow up appointments as instructed by the hospital discharge paperwork.

Telephone interview with Resident #1's PCP on 10/28/21 at 12:40pm revealed:
-He expected the facility to schedule follow up appointments for residents as instructed on the discharge summary.
-Resident #1 should have been scheduled for a follow up appointment within 1 week of his ED discharge.
-It was important that Resident #1 to follow up to ensure that Resident #1 was on the correct antibiotics and that the blood in the urine had resolved.
-If Resident #1 was not seen and his symptoms worsened, he could be at risk for infection and further complications including increased bleeding.

_____

The facility failed to ensure health care referral and follow-up for Resident #3 and Resident #1. Resident #3 had blood sugar results below ordered parameters for which interventions were not implemented as ordered placing the resident at risk for low blood sugars, risk for injury, and death. Resident #1 was not scheduled for a one-week follow-up appointment after a hospital visit for blood in the urine placing him at risk for worsening infection and bleeding complications. The facility's failure was detrimental to the health, welfare and safety of the residents and constitutes a Type B Violation.

_____

The facility provided a plan of correction in

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D 273	Continued From page 11 accordance with G.S. 131D-34 on 10/28/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 12, 2021.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to implement orders to obtain portable oxygen for 1 of 3 sampled residents who required continuous oxygen use (#3). The findings are: Review of Resident #3's current FL-2 dated 06/14/21 revealed: -Diagnoses included diabetes mellitus type 2 (DM), chronic obstructive pulmonary disease (COPD) with exacerbations, acute kidney injury, and hyperkalemia (increased potassium levels in the blood). -She was intermittently disoriented, semi-ambulatory, and used a walker. -There was an order for continuous oxygen via nasal cannula at 2L/minute.	D 276		

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D 276	Continued From page 12 Review of Resident #3's current assessment and care plan dated 06/14/21 revealed the resident wore continuous oxygen at 2L/minute for shortness of breath. Review of a physician's order for Resident #3 dated 10/21/21 revealed there was an order for the resident to receive portable oxygen. Review of a physician's progress note for Resident #3 dated 10/21/21 revealed: -The resident experienced shortness of breath with minimal exertion. -There was an order for the facility to have a durable medical equipment (DME) company evaluate the resident for portable oxygen therapy. Review of Resident #3's August 2021 electronic medication administration record (eMAR) revealed: -There was an entry for oxygen 2L/min via nasal cannula continuously for shortness of breath. -The oxygen was documented as administered once per shift for three shifts each day from 08/01/21-08/31/21. Review of Resident #3's September 2021 eMAR revealed: -There was an entry for oxygen 2L/min via nasal cannula continuously for shortness of breath. -The oxygen was documented as administered once per shift for three shifts each day from 09/01/21-09/30/21. Review of Resident #3's October 2021 eMAR revealed: -There was an entry for oxygen 2L/min via nasal cannula continuously for shortness of breath. -The oxygen was documented as administered	D 276		

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WINSTON GARDENS	205 WEST WATSON STREET WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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once per shift for three shifts each day from 10/01/21-10/27/21.

Observation of Resident #3 on 10/27/21 at 9:00am revealed she was walking out of the living area with a walker and no oxygen on; she was mildly short of breath while walking.

Observation of Resident #3 on 10/27/21 at 10:13am revealed she was sitting in the dining room playing bingo without any oxygen on.

Observation of Resident #3 on 10/27/21 from 11:50am to 12:10pm revealed the resident was in the dining room eating lunch without any oxygen on.

Observation of Resident #3 on 10/28/21 from 9:04am to 9:29am revealed the resident was in the dining room eating breakfast without any oxygen on.

Interview with Resident #3 on 10/27/21 at 3:00pm revealed:
-She only had an oxygen concentrator in her room, she did not have access to any portable oxygen.
-If portable oxygen were available to her, she would wear it.
-She liked to do activities outside of her room but would have to come back to her room and lie down and put her oxygen back on because she needed it due to being tired and short of breath.
-She never refused to wear her oxygen when instructed to do so by staff.

Interview with a medication aide (MA) on 10/27/21 at 3:03pm revealed:
-Resident #3 liked to sit outside a lot and read or play activities such as bingo.

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-Staff would try to get Resident #3 to wear her oxygen when outside of her room, but she would refuse because she only had a room concentrator and no access to portable oxygen.
-She was unsure if Resident #3's primary care provider (PCP) knew she did not have any portable oxygen; she had not reported it to anyone because everyone already knew.

Second interview with an MA on 10/28/21 at 2:24pm revealed Resident #3 was sometimes short of breath and wheezed, usually in the early mornings.

Interview with the lead medication aide/supervisor (MA/S) on 10/28/21 at 2:49pm revealed:
-Resident #3 would sometimes wheeze which was why she was supposed to wear oxygen continuously.
-Resident #3 was encouraged to wear her oxygen all the time but did not have access to portable oxygen outside of her room.

Interview with the Administrator on 10/27/21 at 3:15pm revealed:
-She was responsible to ensure orders were implemented and carried out as ordered.
-Resident #3 did not currently have access to portable oxygen but did receive an order for it on 10/21/21.
-She faxed the order for Resident #3's portable oxygen to the facility's contracted DME company on 10/21/21.
-She believed the DME company was waiting for insurance to approve Resident #3's oxygen, but she was unsure because she had not heard back from them yet.

Telephone interview with the facility's contracted DME company on 10/27/21 at 3:50pm revealed:

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D 276	Continued From page 15 -They had received an order for Resident #3's portable oxygen on 10/21/21. -They had been unable to process the order for Resident #3 because she was not in their system and they had no other information on her. -The order should have been faxed to and processed by the DME company that was responsible for Resident #3's room oxygen concentrator. -No one from the facility had called to inquire or follow-up on Resident #3's portable oxygen order. Interview with Resident #3 on 10/28/21 at 8:35am revealed: -There was no DME company that managed her room oxygen concentrator because she owned it and the facility staff took care of it for her. -No one serviced the concentrator or ensured it ran properly since she brought it from her home and was admitted to the facility on 07/30/2020. Interview with the Administrator on 10/28/21 at 9:31am revealed: -Resident #3 was correct in that there was not a DME company that managed her room oxygen concentrator. -The facility staff ensured Resident #3's concentrator was working properly each day and replaced the oxygen tubing once per month. -She was unaware that the Resident #3 was not in the facility's contracted DME system and unable to process the portable oxygen order; she thought she had followed up with the DME company about processing Resident #3's portable oxygen order. -It was concerning that Resident #3 had continued to go without portable oxygen because she needed to wear it every day. Second interview with the Administrator on	D 276		

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10/28/21 at 4:00pm and 4:14pm revealed:
-She called the DME company today, 10/28/21, to follow up on Resident #3's portable oxygen after it had been brought to her attention the previous day, 10/27/21.
-It was her responsibility to follow up with the DME company sooner and there was no audit process in placed to ensure orders did not get missed.
-She would not have known to follow up with the DME company or that they were unable to fill Resident #3's portable oxygen order if it had not been brought to her attention.
-She assumed the DME company would file Resident #3's insurance and follow up with her if there were any issues filling the portable oxygen order.

Telephone interview with a clinical staff member at Resident #3's PCP office on 10/28/21 at 10:57am revealed Resident #3 needed her portable oxygen because she had a history of COPD and the resident's PCP would be concerned that she had not received it as ordered.

Telephone interview with Resident #3's PCP on 10/28/21 at 12:29pm revealed:
-He last saw Resident #3 on 10/21/21.
-The resident was short of breath with activity due to her COPD which was why he ordered portable oxygen for her.
-He expected the resident to have received portable oxygen within 1-2 days of his order.
-He expected the facility to follow up with the contracted DME company if they had not received the oxygen within 1-2 days.
-He was concerned that the resident did not have her portable oxygen because it could exacerbate her symptoms of shortness of breath and heart

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D 276	Continued From page 17 failure and she would not get better.	D 276		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to have a matching therapeutic diet menu for 2 of 3 sampled residents with a physician's order for a no concentrated sweets (NCS) diet (#1, #3) and chopped meats (#3). The findings are: 1.Review of Resident #3's current FL-2 dated 06/14/21 revealed: -Diagnoses included diabetes mellitus type 2 (DM), chronic obstructive pulmonary disease (COPD) with exacerbations, acute kidney injury, and hyperkalemia (increased potassium levels in the blood). -She was intermittently disoriented. a. Review of a physician's diet order for Resident #3 dated 06/14/21 revealed there was an order for an NCS diet. Review of the revolving "Weekly Menu" posted in the dining room on 10/27/21 at 9:35am revealed:	D 296		

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D 296	Continued From page 18 -There was no therapeutic diet menu. -Lunch on 10/27/21 was supposed to consist of baked chicken breast, hash brown casserole, seasoned carrots, dinner roll, fruited gelatin, and beverage of choice. -There was a substitution for lunch posted near the kitchen door for 10/27/21 that was for beef tips with gravy, mashed potatoes, orange gelatin, squash, wheat bread, and fruit punch. Review of the thereputic diet list posted in the kitchen on 10/27/21 at 12:14pm revealed Resident #3 was supposed to be served a NCS diabetic diet. Observation of the lunch meal service on 10/27/21 from 11:50am to 12:10pm revealed: -Resident #3 was served bite sized beef tips with gravy, mashed potatoes, orange gelatin with fruit cocktail in it, sautéed squash, one slice of wheat bread, and red fruit punch. -Resident #3 ate and drank 100% of her lunch meal served. -Resident #3 received the same lunch meal tray as all the other residents in the dining room. Interview with Resident #3 on 10/28/21 at 8:35am revealed she did not receive a specialized diet for her diabetes at the facility. Observation of the fruit punch package on 10/27/21 at 12:04pm revealed it contained dextrose and sugar. Interview with the dietary aide 10/27/21 at 12:10pm revealed the fruit punch was prepared with sugar; the facility did not have any sugar free juice or punch. Refer to interview with the dietary aide on	D 296		

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D 296	Continued From page 19 10/27/21 at 12:10pm. Refer to interview with a second dietary aide on 10/28/21 at 8:20am. Refer to interview with the Administrator on 10/28/21 at 9:31am. Refer to telephone interview a clinical provider at the facility's contracted primary care provider's (PCP) office on 10/28/21 at 10:57am. Refer to telephone interview with the facility's contracted PCP office on 10/28/21 at 12:29pm. b. Review of a physician's diet order for Resident #3 dated 06/14/21 revealed there was an order for the resident to have chopped meats. Review of the revolving "Weekly Menu" posted in the dining room on 10/27/21 at 9:35am revealed: -There was no therapeutic diet menu. -Breakfast on 10/28/21 was supposed to consist of juice of choice, beverage of choice, cereal of choice, scrambled eggs, bacon, biscuit, and milk. -There was no substitution menu posted. Review of the thereputic diet list posted in the kitchen on 10/27/21 at 12:14pm revealed: -Resident #3 was supposed to be served a NCS diabetic diet. -There were no instructions to cut up Resident #3's meat. Observation of the breakfast meal service on 10/28/21 from 9:04am to 9:29am revealed: -A different meal was served as compared to what was posted on the menu. -Resident #3 was served milk, water, apple juice, one whole sausage patty, grits, scrambled eggs,	D 296		

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and toast.
-Resident #3 ate and drank 100% of her breakfast meal served.
-Resident #3 received the same breakfast meal tray as all the other residents in the dining room.
-Resident #3's sausage patty was not cut up by staff and she was unable to cut the sausage patty herself taking bites from it instead.

Interview with Resident #3 on 10/28/21 at 8:35am revealed she did not receive a specialized diet at the facility and the facility staff never cut up her meats.

Interview with a second dietary aide on 10/28/21 at 8:20am revealed:
-She prepared the breakfast that day, 10/28/21.
-She was unaware that Resident #3 required her meats to be cut up because it was not listed on teh theraputic diet list.

Telephone interview with a clinical provider at Resident #3's primary care provider's (PCP) on 10/28/21 at 10:57am revealed she expected the resident's meats to be cut up for her safety to reduce the risk of her choking.

Telephone interview with Resident #3's PCP on 10/28/21 at 12:29pm revealed he expected the facility staff to cut up the resident's meats for her safety regarding choking.

Refer to interview with the dietary aide on 10/27/21 at 12:10pm.

Refer to interview with a second dietary aide on 10/28/21 at 8:20am.

Refer to interview with the Administrator on 10/28/21 at 9:31am.

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D 296	Continued From page 21 Refer to telephone interview a clinical provider at the facility's contracted primary care provider's (PCP) office on 10/28/21 at 10:57am. Refer to telephone interview with the facility's contracted PCP office on 10/28/21 at 12:29pm. 2. Review of Resident #1's current FL-2 dated 03/26/21 revealed diagnoses included type 2 diabetes mellitus, left lower leg amputation, hypertension, and peripheral vascular disease. Review of Resident #1's physician orders dated 07/17/21 revealed there was an order for a no concentrated sweets (NCS) diet. Review of the revolving "Weekly Menu" posted in the dining room on 10/27/21 at 9:35am revealed: -There was no therapeutic diet menu. -Lunch on 10/27/21 was supposed to consist of baked chicken breast, hash brown casserole, seasoned carrots, dinner roll, fruited gelatin, and beverage of choice. -There was a substitution for lunch posted near the kitchen door for 10/27/21 that was for beef tips with gravy, mashed potatoes, orange gelatin, squash, wheat bread, and fruit punch. Review of the thereputic diet list posted in the kitchen on 10/27/21 at 12:14pm revealed Resident #1 was supposed to be served a NCS diabetic diet. Review of Resident #1's August 2021 electronic medication administration record (eMAR) revealed Resident #1's blood sugars ranged from 114 to 565. Review of Resident #1's September 2021 eMAR	D 296		

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revealed Resident #1's blood sugars ranged from 101 to 496.

Review of Resident #1's October 2021 eMAR revealed Resident #1's blood sugars ranged from 81 to 479.

Observation of lunch meal service on 10/27/21 at 12:00pm revealed Resident #1 was served beef tips, mashed potatoes, squash and orange gelatin and he ate 100% of the meal.

Interview with Resident #1 on 10/28/21 at 12:30pm revealed:
-He enjoyed the food that was served at the facility.
-He ate the same thing as the rest of the residents.
-He was served a dessert or sweet treat with most meals.

Refer to interview with the dietary aide on 10/27/21 at 12:10pm.

Refer to interview with a second dietary aide on 10/28/21 at 8:20am.

Refer to interview with the Administrator on 10/28/21 at 9:31am.

Refer to telephone interview a clinical provider at the facility's contracted primary care provider's (PCP) office on 10/28/21 at 10:57am.

Refer to telephone interview with the facility's contracted PCP office on 10/28/21 at 12:29pm.

_____

Interview with the dietary aide on 10/27/21 at 12:10pm revealed:
-She prepared lunch on 10/28/21 and all the

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residents were given the same thing.
-She was not aware of what a therapeutic diet was and was not aware any of the residents were supposed to receive any special diets.
-She had been a cook at the facility for about three weeks and had not received any training on food preparation or therapeutic diets/menus.
-The Administrator had prepared the orange gelatin; she was unsure how it was prepared.

Interview with a second dietary aide on 10/28/21 at 8:20am revealed:
-She has been a dietary aide at the facility for two years but had not received any specialized training to function in the role; she used her knowledge of working in fast food previously to prepare the food at the facility.
-She tried to prepare all meals according to the posted menu, but sometimes she would substitute if the facility was out of the ingredients or if a resident requested something different to eat.
-The facility had a list of residents on a therapeutic diet, but everyone received the same meal and there were no therapeutic diet menus available.
-For residents on a NCS diet, it meant that she was not to give the residents second helpings of foods with sugar in them until their finger stick blood sugar (FSBS) had been evaluated.
-Sometimes for dessert, she would only serve the residents on a NCS diet a half a piece of cake instead of a whole piece after their meal.
-If a resident on an NCS diet and their FSBS was good, she would give them an extra serving if requested.
-The facility did offer sugar free snacks versus the normal snacks each day.

Interview with the Administrator on 10/28/21 at

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9:31am revealed:
-She prepared the orange gelatin that had been served at lunch on the previous day, 10/27/21, using canned fruit cocktail, an orange flavored orange gelatin packet, and regular sugar.
-She did not consider that the residents on NCS would need a sugar free option of the orange gelatin.
-There were no therapeutic diet menus available at the facility.
-She was unsure what kind of training the dietary aides had received because they were both hired prior to her working at the facility.
-She had recently realized the facility menus were old and had reached out to a company to come do some training and update the facility menus, but that had not been scheduled yet.
-The dietary aides always prepared the same menu of food for all the residents each day.
-She had never asked the dietary aides if they were aware of what a therapeutic diet was or how to prepare foods differently for residents on a therapeutic diet, she had not thought about it.

Telephone interview with a clinical provider at Resident #3's primary care provider's (PCP) on 10/28/21 at 10:57am revealed:
-She expected the facility to serve therapeutic diets as ordered for the well-being of the residents.
-NCS diet was ordered for the resident to help treat and maintain her diabetes and keep her FSBS in a normal and safe level.

Telephone interview with Resident #3's PCP on 10/28/21 at 12:29pm revealed:
-He expected therapeutic diets to be accommodated and served to residents as ordered.
-It was imperative that the facility served food

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D 296	Continued From page 25 according to the NCS diet to manage the residents DM. -Not being served a therapeutic NCS diet would contribute to the resident's FSBS being unstable.	D 296		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on interviews, and record reviews the facility failed to maintain an accurate and current list of residents with physician-ordered therapeutic diets for guidance of food service staff for 1 of 3 sampled residents with an order for chopped meats (#1). The findings are: Review of Resident #3's current FL-2 dated 06/14/21 revealed: -Diagnoses included diabetes mellitus type 2 (DM), chronic obstructive pulmonary disease (COPD) with exacerbations, acute kidney injury (AKI), and hyperkalemia (increased potassium levels in the blood). -There was a diet order for no concentrated sweets (NCS) diet. Review of a physician's diet order for Resident #3	D 309		

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dated 06/14/21 revealed:
-There was an order for an NCS diet.
-There was an order for the resident to have chopped meats.

Review of a therapeutic diet list posted in the facility kitchen on 10/27/21 at 12:14pm revealed:
-Resident #3 was listed to have an NCS diet as of 01/07/21.
-Resident #3 did not have any guidance on the list to have cut up meats.

Interview with Resident #3 on 10/28/21 at 8:35am revealed she did not receive a specialized diet for her diabetes at the facility and the facility staff never cut up her meats.

Interview with a dietary aide on 10/28/21 at 8:20am revealed she was unaware that Resident #3 required her meats to be cut up because it was not listed that way on the therapeutic diet list.

Interview with the Administrator on 10/28/21 at 4:14pm revealed:
-She was unaware that Resident #3's order to have her meats chopped was not on the therapeutic diet list posted in the kitchen; it must have been missed.
-It was her responsibility to ensure the therapeutic diet list was posted, accurate, and up to date.
-It was important for residents to receive their therapeutic diets as ordered for their diagnoses.

Telephone interview with Resident #3's PCP on 10/28/21 at 12:29pm revealed:
-He expected the facility staff to cut up the resident's meats for her safety regarding choking.
-He expected the facility to maintain an accurate list of therapeutic diets to be accommodated and served to residents as ordered.

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D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 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 serve therapeutic diets as ordered by the primary care provider (PCP) for 1 of 3 sampled residents (#2) who had a diet order for supplemental nutrition shakes. The findings are: Review of Resident #2's current FL-2 dated 06/14/21 revealed the resident had a diagnosis including moderate intellectual developmental disability (IDD), depression, anxiety, hypertension, and gastroesophageal reflux disease (GERD). Review of a physician order for Resident #2 dated 09/16/20 revealed an order for supplement shakes, give 1 shake by mouth daily. Review of Resident #2's physician order dated 10/28/21 revealed there was an order for supplement shakes, give 1 shake daily for supplement at 8:00am. Observation of Resident #2 during breakfast meal	D 310		

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service on 10/28/21 between 09:00am -09:30am revealed :
-Resident #2 had toast, scrambled eggs, grits and sausage, water, juice and milk.
-Resident #2 was not served a supplement shake.

Observation on 10/27/21 at 4:00pm revealed there were no supplement shakes in the refrigerator located in the medication room, the kitchen, or in the overstock supply.

Interview with a medication aide (MA) on 10/28/21 at 2:30pm revealed:
-She informed the Administrator that Resident #2 need some nutritional shakes on 10/22/21.
-The facility had been out of nutritional shakes since 10/23/21.
-The Administrator was responsible for ordering Resident #2's supplement shakes.
-She had not administered Resident #2 any supplement shakes since 10/22/21.
-She documented in error that she had administered supplement shakes to Resident #2 10/23/21-10/27/21 on his electronic medication administration record (eMAR).
-She should have slowed down and paid more attention to her documentation on Resident #2's eMAR.

Interview with the Administrator on 10/28/21 at 4:16pm revealed:
-She was not aware that the facility was out of supplement shakes on 10/23/21.
-She expected MAs to inform her within 3 days when Resident #2 was low on supplment shakes.
-Supplement shakes were ordered every 2 weeks.
-She expected MA's to administer medications and supplements as ordered and document why

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D 310	Continued From page 29 a resident did not get a medication or supplement as appropriate. Telephone interview with Resident #2's primary care provider on 10/28/21 at 12:29pm revealed the resident was to receive supplement shakes as prescribed and ordered to support his health and nutrition.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure medications were administered as ordered for 4 of 5 sampled residents (#1, #3, #4, and #5) including errors with insulin (#1, #4, and #5) and a diuretic and nebulizer (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 03/26/21 revealed: -Diagnoses included type 2 diabetes mellitus. -There was an order for Humalog Kwikpen, check fingerstick blood sugars (FSBS) three times a day	D 358		

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before meals and cover with sliding scale insulin (SSI) if blood sugar is over 200 (Humalog is a fast acting insulin used to lower blood sugar).
-Sliding scale insulin orders were as follows: FSBS 0-200= zero-units, 201-250= 2-units, 251-300= 4-units, 301-350= 6-units, 351-400= 8-units, greater than 400=10-units.

Review of Resident #1's August 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Humalog Kwikpen, check FSBS three times a day before meals per sliding scale: FSBS 0-200= zero units, 201-250= 2-units, 251-300= 4-units, 301-350= 6-units, 351-400= 8-units, greater than 400=10-units.
-Resident #1's blood sugars ranged from 114 to 565.
-Resident #1's blood sugar on 08/12/21 at 8:00am was 198.
-Humalog 1-unit was documented as administered on 08/12/21 at 8:00am; based on the SSI order the resident should have received zero insulin.
-Resident #1's blood sugar on 08/12/21 at 12:00pm was 151.
-Humalog 1-unit was documented as administered on 08/12/21 at 12:00pm; based on the SSI order the resident should have received zero insulin.
-Resident #1's blood sugar on 08/13/21 at 5:00pm was 177.
-Humalog 1-unit was documented as administered on 08/13/21 at 5:00pm; based on the SSI order the resident should have received zero insulin.
-Resident #1's blood sugar on 08/15/21 at 5:00pm was 352.
-Humalog 10-units were documented as administered on 08/15/21 at 5:00pm; based on

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the SSI order the resident should have received Humalog 8-units.
-Resident #1's blood sugar on 08/22/21 at 5:00pm was 540.
-Humalog 14-units were documented as administered on 08/22/21 at 5:00pm; based on the SSI order the resident should have received Humalog 10-units.
-Resident #1's blood sugar on 08/26/21 at 8:00am was 320.
-Humalog 8-units were documented as administered on 08/26/21 at 8:00am; based on the SSI order the resident should have received Humalog 6-units.
-Resident #1's blood sugar on 08/27/21 at 5:00pm was 417.
-Humalog 8-units were documented as administered on 08/27/21 at 5:00pm; based on the SSI order the resident should have received Humalog 10-units.
-Resident #1 was administered more insulin than ordered 6 times and less insulin than ordered 1 time.

Review of Resident #1's September 2021 eMAR revealed:
-There was an entry for Humalog Kwikpen, check FSBS three times a day before meals per sliding scale: if blood sugar is over 200 as follows: FSBS 0-200= zero units, 201-250= 2-units, 251-300= 4-units, 301-350= 6-units, 351-400= 8-units, greater than 400=10-units.
-Resident #1's blood sugars ranged from 101 to 496.
-Resident #1's blood sugar on 09/05/21 at 12:00pm was 359.
-Humalog 6-units were documented as administered on 09/05/21 at 12:00pm; based on the SSI order the resident should have received Humalog 8-units.

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-Resident #1's blood sugar on 09/07/21 at 5:00pm was 496.
-Humalog 12-units were documented as administered on 09/07/21 at 5:00pm; based on the SSI order the resident should have received Humalog 10-units.
-Resident #1's blood sugar on 09/14/21 at 12:00pm was 329.
-Humalog was not documented as administered on 09/14/21 at 12:00pm; based on the SSI order the resident should have received Humalog 6-units.
-Resident #1's blood sugar on 09/18/21 at 12:00pm was 240.
-Humalog 4-units were documented as administered on 09/18/21 at 12:00pm; based on the SSI order the resident should have received Humalog 2-units.
-Resident #1's blood sugar on 09/22/21 at 12:00pm was 376.
-Humalog was not documented as administered on 09/22/21 at 12:00pm; based on the SSI order the resident should have received Humalog 8-units.
-Resident #1's blood sugar on 09/24/21 at 8:00am was 223.
-Humalog was not documented as administered on 09/24/21 at 8:00am; based on the SSI order the resident should have received Humalog 2-units.
-Resident #1 was administered more insulin than ordered 2 times and less insulin than ordered 4 times.

Review of Resident #1's October 2021 eMAR revealed:
-There was an entry for Humalog Kwikpen, check FSBS three times a day before meals per sliding scale: FSBS 0-200= zero units, 201-250= 2-units, 251-300= 4-units, 301-350= 6-units, 351-400=

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8-units, greater than 400=10-units.
-Resident #1's blood sugars ranged from 81 to 479.
-Resident #1's blood sugar on 10/03/21 at 8:00am was 197.
-Humalog 1-unit was documented as administered on 10/03/21 at 8:00am; based on the SSI order the resident should have received zero Humalog.
-Resident #1's blood sugar on 10/07/21 at 8:00am was 271.
-Humalog 6-units were documented as administered on 10/07/21 at 8:00am; based on the SSI order the resident should have received Humalog 4-units.
-Resident #1's blood sugar on 10/07/21 at 12:00pm was 254.
-Humalog 6-units were documented as administered on 10/07/21 at 12:00pm; based on the SSI order the resident should have received Humalog 4-units.
-Resident #1's blood sugar on 10/08/21 at 8:00am was 350.
-Humalog 10-units were documented as administered on 10/08/21 at 8:00am; based on the SSI order the resident should have received Humalog 6-units.
-Resident #1's blood sugar on 10/14/21 at 8:00am was 291.
-Humalog was not documented as administered on 10/14/21 at 8:00am; based on the SSI order the resident should have received Humalog 4-units.
-Resident #1's blood sugar on 10/17/21 at 8:00am was 229.
-Humalog 4-units were documented as administered on 10/17/21 at 8:00am; based on the SSI order the resident should have received Humalog 2-units.
-Resident #1's blood sugar on 10/17/21 at

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5:00pm was 288.
-Humalog 8-units were documented as administered on 10/17/21 at 5:00pm; based on the SSI order the resident should have received Humalog 4-units.
-Resident #1's blood sugar on 10/26/21 at 8:00am was 205.
-Humalog was not documented as administered on 10/26/21 at 8:00am; based on the SSI order the resident should have received Humalog 2-units.
-Resident #1 was administered more insulin than ordered 6 times and less insulin than ordered 2 times.

Interview with the medication aide (MA) on 10/28/21 at 2:20pm revealed Resident #1 was administered insulin according to the sliding scale order.

Interview with the lead MA/Supervisor on 10/28/21 at 2:40pm revealed:
-She based the insulin Resident #1 received from the SSI order but there were times that she adjusted the amount of insulin.
-If she saw Resident #1 with a regular can of soda, she would give the resident a "little more" insulin.
-If she did not think that Resident #1 was going to eat much of a meal, she wouldn't give the resident all the insulin that was ordered.
-She did not call the primary care provider (PCP) when she altered Resident #1's insulin amount.
-She had personal experience with having diabetes and used that to help influence her decision in adjusting Resident #1's sliding scale insulin order.

Interview with the Administrator on 10/28/21 at 4:15pm revealed:

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-She expected staff to administer Resident #1 his SSI as ordered.
-She was not aware that a staff member was adjusting Resident #1's insulin orders without calling the physician.
-She was concerned that staff was adjusting Resident #1's insulin because it could cause him to have uncontrolled blood sugars.

Telephone interview with Resident #1's primary care provider on 10/28/21 at 12:40pm revealed:
-He was not aware Resident #1 was not receiving the ordered dose of insulin which can cause issues when he went to adjust his medication orders.
-He expected Resident #1 to receive his SSI as ordered.
-He was concerned that staff was not administering Resident #1's insulin as ordered; and it could have caused Resident #1 to have high blood sugars or low blood sugars.
-It was a very dangerous practice for staff to alter dosage without consulting the PCP first.

2. Review of Resident #3's current FL-2 dated 06/14/21 revealed:
-Diagnoses included diabetes mellitus type 2 (DM), chronic obstructive pulmonary disease (COPD) with exacerbations, acute kidney injury (AKI), and hyperkalemia (increased potassium levels in the blood).
-She was intermittently disoriented, semi-ambulatory, and used a walker.

Review of Resident #3's current assessment and care plan dated 06/14/21 revealed the resident wore continuous oxygen at 2L/minute for shortness of breath.

Review of a physician's progress note for

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Resident #3 dated 10/21/21 revealed:
-The resident experienced shortness of breath with minimal exertion and had bilateral lower extremity edema (swelling from fluid build-up).
-She was given a new diagnosis of heart failure that required a treatment plan.
-There was an order for Demodex 10mg daily.

Review of a physician's order for Resident #3 dated 10/21/21 revealed there was an order for the resident to receive Demodex 10mg daily (a diuretic used to remove excess fluid from around the heart and the body).

Review of Resident #3's October 2021 electronic medication administration record (eMAR) revealed there was no entry or documentation of administration of Demodex 10mg daily.

Observation of medications on hand for Resident #3 on 10/27/21 at 3:30pm revealed there was no Demodex on hand for the resident.

Interview with a medication aide (MA) on 10/27/21 at 3:37pm revealed:
-She did not know Resident #3 was supposed have Demodex 10mg on hand.
-The lead medication aide/supervisor (MA/S) was responsible for medication cart audits and ensuring resident's medications were on hand.

Interview with a second MA on 10/28/21 at 2:24pm revealed:
-The Administrator was responsible to follow up with the pharmacy if medications did not come in.
-She would not know a medication did not come in if it was not already on the eMAR scheduled to be administered.
-She was not aware that Resident #3 was missing Demodex on the medication cart or on

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D 358	Continued From page 37 her eMAR. Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/28/21 at 12:10pm revealed: -The pharmacy had not received an order for Resident #3's Demodex 10mg daily. -When the pharmacy received an order from the facility, they would process and fill the order, deliver the medication to the facility either the same day or the following day, and enter the order on the resident's eMAR to be approved by the facility for medication administration. -Demodex was a diuretic commonly used for heart failure patients to remove excess fluid that built up around the heart. -If Resident #3 did not receive her Demodex as ordered, it was possible that her heart failure could worsen and increase her symptoms of shortness of breath and edema. -It was concerning that Resident #3 had not received her Demodex as ordered with her new diagnosis of heart failure. Interview with the lead MA/S on 10/28/21 at 2:49pm revealed: -If a medication was not on the medication cart or eMAR, the MAs would not know the medication was ordered for a resident. -It was her or the Administrator's responsibility to fax medication orders to the pharmacy to be processed. -It was her or the Administrator's responsibility to approve medication orders when the medication arrived from the pharmacy. -She was not aware Resident #3's Demodex order had not been received by the pharmacy. -There was no process in place to ensure the pharmacy received a medication order or to follow up on medication orders that had not been	D 358		

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received after faxing them to the pharmacy.

Interview with the Administrator on 10/27/21 at 3:15pm revealed:
-It was her responsibility to ensure orders were faxed to the pharmacy and implemented as ordered as soon as possible.
-She faxed Resident #3's Demodex 10mg order to the pharmacy on 10/21/21.
-Once the pharmacy received the order, they would usually send the medication that same day, or the next day, and enter the medication order on the resident's eMAR.
-Once the medication was received at the facility, she or the lead MA/S would review the medication against the order and approve the medication for administration on the eMAR.
-There was no process in placed to ensure the pharmacy received the faxed order, or to ensure orders did not get overlooked or forgotten by the facility after faxing the order.
-She was not aware that Resident #3's Demodex had not come in and was not available.

Second interview with the Administrator on 10/28/21 at 4:15pm revealed:
-She was not aware that the pharmacy had not received Resident #3's order for Demodex 10mg.
-It was her responsibility to follow up on orders that had not been processed.
-There was no audit process in place to ensure orders for residents did not get missed.
-It was important for Resident #3 to have her Demodex as ordered due to her new diagnosis of heart failure.

Telephone interview with a clinical staff member at Resident #3's PCP office on 10/28/21 at 10:57am revealed Resident #3 needed her Demodex 10mg because she had a new

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diagnosis of heart failure and the resident's primary care provider (PCP) would be concerned that she did not have it available to her as ordered due to her diagnoses.

Telephone interview with Resident #3's PCP on 10/28/21 at 12:29pm revealed:
-He last saw Resident #3 on 10/21/21.
-He wrote the resident an order for Demodex to treat fluid build-up from her new diagnosis of heart failure and her history of hypertension (high blood pressure).
-He expected the facility to fax, implement, and follow-up on his orders within 1-2 days to ensure the resident received the treatment that she needed per his orders.
-If the resident did not have her Demodex as ordered, she could have exacerbation of her symptoms of shortness of breath and edema and it would prevent her from getting better.

3. Review of Resident #4's current FL-2 dated 01/19/21 revealed diagnoses included type 2 diabetes mellitus.

a. Review of Resident #4's current FL-2 dated 01/19/21 revealed there was an order for Lantus Solostar, inject 26-units daily (Lantus is a long-acting insulin used to lower blood sugar)

Review of the prescribing information from the Lantus Solostar manufacturer revealed:
-After the needle was attached, a safety test should have been performed.
-The safety test is performed by dialing a test dose of 2 units.
-The medication aide shall press the injection button and check to see that insulin comes out of the needle.

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Observation of Resident #4 receiving her morning medications on 10/28/21 revealed:
-Resident #4's fingerstick blood sugar was 101 at 8:00am.
-The medication aide (MA) administered 26-units of Lantus Solostar Pen into Resident #4's abdomen at 8:02am.
-The MA did not prime the insulin pen by performing a 2-unit air shot to remove any air bubbles and to make sure the insulin was flowing through the needle and that the resident received the full dose of insulin.

Review of Resident #4's October 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Lantus with instructions to administer 26 units daily, scheduled for administration at 8:00am.
-Lantus was documented as administered on 10/28/21 at 8:00am.

Refer to the telephone interview with a pharmacist at the facility's contracted pharmacy on 10/28/21 at 12:11pm.

Refer to the interview with the MA on 10/28/21 at 2:20pm.

Refer to the interview with the lead MA/Supervisor on 10/28/21 at 2:40pm.

Refer to the interview with the Administrator on 10/28/21 at 4:15pm.

Refer to the telephone interview with the facility's contracted primary care provider (PCP) on 10/28/21 at 12:40pm.

Based on observations, interviews, and record

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reviews it was determined Resident #4 was not interviewable.

Attempted telephone interview with a representative of the training agency that provided educational in-services to the facility staff on 10/28/21 at 2:03pm was unsuccessful.

b. Review of Resident #1's physician orders dated 07/17/21 revealed there was an order for Levemir 37-units every morning (Levemir is a long-acting insulin used to lower blood sugar).

Review of the prescribing information from the Lantus Solostar manufacturer revealed:
-After the needle was attached, a safety test should have been performed.
-The safety test is performed by dialing a test dose of 2 units.
-The medication aide shall press the injection button and check to see that insulin comes out of the needle.

Observation of Resident #1 receiving his morning medications on 10/28/21 revealed:
-Resident #1's finger stick blood sugar was 133 at 8:36am.
-The medication aide (MA) administered 37-units of Levemir Flex-Touch Pen insulin into Resident #1's abdomen at 8:38am.
-The MA did not prime the insulin pen by performing a 2-unit air shot to remove any air bubbles and to make sure the insulin was flowing through the needle and that the resident received the full dose of insulin.

Interview with Resident #1 on 10/28/21 at 12:30pm revealed:
-The MA administered his insulin because he had diabetes.

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D 358	Continued From page 42 -He was not sure how the insulin was prepared because the MA was responsible for administering him his insulin. Refer to the telephone interview with a pharmacist at the facility's contracted pharmacy on 10/28/21 at 12:11pm. Refer to the interview with the MA on 10/28/21 at 2:20pm. Refer to the interview with the lead MA/Supervisor on 10/28/21 at 2:40pm. Refer to the interview with the Administrator on 10/28/21 at 4:15pm. Refer to the telephone interview with the facility's contracted primary care provider (PCP) on 10/28/21 at 12:40pm. Attempted telephone interview with a representative of the training agency that provided educational in-services to the facility staff on 10/28/21 at 2:03pm was unsuccessful. _____ Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/28/21 at 12:11pm revealed: -Insulin pens should be primed with a 2-unit air dose according to manufacturer's recommendation. -It was important to follow the manufacturer's recommendations when administering insulin using a pen to ensure the resident received the correct dosage of insulin. -Failure to ensure residents received the correct dose of insulin could cause them to experience hyperglycemia (high blood sugar) and	D 358		

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hypoglycemia (low blood sugar), putting them at risk for such adverse events as falls.

Interview with the MA on 10/28/21 at 2:20pm revealed:
-She was not aware of the manufacturer's recommendation of priming insulin pens with 2-units of air prior to insulin administration.
-She was trained on using the insulin pens by a MA that was training her on the medication cart during her orientation.

Interview with the lead MA/Supervisor on 10/28/21 at 2:40pm revealed:
-She was not aware of the manufacturer's recommendation of priming insulin pens with 2-units of air prior to insulin administration.
-She was trained on insulin administration including pens at a previous facility run by the same company when she worked there.
-She was not able to recall if she had any additional training by the facility on insulin administration.

Interview with the Administrator on 10/28/21 at 4:15pm revealed:
-She was not aware that MAs were not administering insulin according to the manufacturer's recommendations.
-She believed that there was some insulin administration training completed by the outside agency used for staff training in the summer or fall of 2020 but could not recall specifically when that was done or what that training entailed.

Telephone interview with the facility's contracted primary care provider (PCP) on 10/28/21 at 12:40pm revealed:
-He expected staff to administer insulin using the manufacturer's guidelines to ensure residents

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were receiving the proper dose of insulin.
-Residents who did not receive the proper dose of insulin were at a higher risk for uncontrolled blood sugars.

4. Review of Resident #5's current FL-2 dated 01/12/21 revealed:
-Diagnoses included diabetes.
-There was an order for Novolin 70/30, administer 12-units before breakfast and evening meal with instructions to hold if the blood sugar is less than 100 (Novolin 70/30 is an insulin mixture with both short and long-acting insulin used to control diabetes that starts to lower blood sugar approximately 30 minutes after administration).

Observation of Resident #5 receiving his morning medications on 10/28/21 revealed:
-Resident #5's blood sugar was 166 at 8:10am.
-The medication aide (MA) administered Novolin 70/30, 12-units to Resident #5 in his left upper arm at 8:14am.

Interview with the MA on 10/28/21 revealed breakfast was usually served between 8:00am and 8:30am.

Observation on 10/28/21 revealed Resident #5 was served breakfast at 9:09am, 55 minutes after receiving Novolin 70/30 insulin.

Review of Resident #5's October 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Novolin 70/30 with instructions to administer 12 units before breakfast and evening meal, hold if blood sugar less than 100, scheduled for administration at 8:00am and 5:00pm.
-Novolin 70/30 12 units was documented as

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D 358	Continued From page 45 administered at 8:00am on 10/28/21. Interview with the MA on 10/28/21 at 2:20pm revealed: -She was aware that Resident #5 should eat within 30 minutes of administering the Novolin 70/30 insulin. -She normally administered insulin immediately before breakfast was being served but breakfast was delayed this morning. Interview with the Administrator on 10/28/21 at 4:15pm revealed she expected Resident #5 to receive his Novolin 70/30 insulin no more than 30 minutes prior to eating. Telephone interview with Resident #5's primary care provider (PCP) on 10/28/21 at 12:40pm revealed: -He expected Resident #5 to receive his meal within 30 minutes of being administered Novolin 70/30 insulin. -It was concerning that Resident #5 had to wait more than 30 minutes to eat because there was shorting acting insulin in the mixture that could cause his blood sugar to drop dangerously low causing increased risk for falls and other complications. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable. 5. Review of Resident #3's current FL-2 dated 06/14/21 revealed: -Diagnoses included diabetes mellitus type 2 (DM), chronic obstructive pulmonary disease (COPD) with exacerbations, acute kidney injury (AKI), and hyperkalemia (increased potassium levels in the blood).	D 358		

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-She was intermittently disoriented, semi-ambulatory, and used a walker.
-There was an order dated 06/14/21 revealed an order for Iprat-albuterol 0.5-3(2.5)mg/3ml, give 1 vial every 4 hours as needed via nebulizer for shortness of breath.

Review of Resident #3's August 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Iprat-albuterol 0.5-3(2.5)mg/3ml, give 1 vial every 4 hours as needed via nebulizer for shortness of breath.
-The Iprat-albuterol 0.5-3(2.5)mg/3ml was documented as administered once on 08/21/21 at an unknown time in the month of August 2021.

Review of Resident #3's September 2021 eMAR revealed:
-There was an entry for Iprat-albuterol 0.5-3(2.5)mg/3ml, give 1 vial every 4 hours as needed via nebulizer for shortness of breath.
-There was no documentation of administration of Iprat-albuterol 0.5-3(2.5)mg/3ml in the month of September 2021.

Review of Resident #3's October 2021 eMAR revealed:
-There was an entry for Iprat-albuterol 0.5-3(2.5)mg/3ml, give 1 vial every 4 hours as needed via nebulizer for shortness of breath.
-There was no documentation of administration of Iprat-albuterol 0.5-3(2.5)mg/3ml in the month of October 2021.

Observation of Resident #3's medications on hand on 10/27/21 at 3:30pm revealed there was no Iprat-albuterol 05.-3(2.5)mg/3ml on hand and available for administration.

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Interview with a medication aide (MA) on 10/27/21 at 3:37pm revealed:
-She did not know why Resident #3's Iprat-albuterol 0.5-3(2.5)mg/3ml was not available on the medication cart.
-She did not know how long the Iprat-albuterol 0.5-3(2.5)mg/3ml had been unavailable to Resident #3.
-Resident #3 was last administered the Iprat-albuterol 0.5-3(2.5)mg/3ml on 08/17/21 and she was unsure if the resident had needed the medication since that date.
-The lead medication aide/supervisor (MA/S) was responsible for medication cart audits and reordering resident's medications to ensure they were on hand.

Interview with a second MA on 10/28/21 at 2:24pm revealed:
-Resident #3 was sometimes short of breath and wheezed, usually in the early mornings.
-The last time Resident #3 was short of breath that she could recall was about 2-weeks ago.
-She reported to the Administrator about one month ago that Resident #3's Iprat-albuterol 0.5-3(2.5)mg/3ml needed to be refilled but was not responsible to follow up to ensure it had been completed.

Interview with the lead medication aide/supervisor (MA/S) on 10/28/21 at 2:49pm revealed:
-Resident #3 would sometimes wheeze which was why she was supposed to wear continuous oxygen.
-She was not sure why Resident #3 did not have her Iprat-albuterol 0.5-3(2.5)mg/3ml available to her and she was unsure when she had run out.
-Resident #3 did not usually ask to use her Iprat-albuterol 0.5-3(2.5)mg/3ml vials but could use it if she needed for wheezing or shortness of

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breath.
-She did not normally administer the Iprat-albuterol 0.5-3(2.5)mg/3ml vials to Resident #3 unless she asked for it.
-She could not remember the last time Resident #3 used her Iprat-albuterol 0.5-3(2.5)mg/3mg vials.
-She was responsible for medication cart audits twice weekly to ensure residents had their medications on hand to be administered as ordered.
-She last completed medication cart audits last week.
-She never documented her medication cart audits and was unsure when the last time she ordered Iprat-albuterol 0.5-3(2.5)mg/3ml for Resident #3.

Interview with the Administrator on 10/27/21 at 3:15pm revealed:
-It was the lead MA/S's responsibility to perform medication cart audits twice per week to ensure medications were available to residents as needed and as ordered.
-There was no documentation that medication cart audits had been done.
-She was unaware that Resident #3 did not have any Iprat-albuterol 0.5-3(2.5)mg/3ml available for administration.
-It was concerning that Resident #3 did not have the Iprat-albuterol 0.5-3(2.5)mg/3ml available because she might need the medication if she had difficulty breathing due to an exacerbation of her COPD which she had a history of.

Second interview with the Administrator on 10/28/21 at 4:15pm revealed:
-It was her responsibility to follow up on orders that had not been processed or needed attention.
-There was no audit process in place to ensure

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orders for residents did not get missed.
-It was important for Resident #3 to have her Iprat-albuterol 0.5-3(2.5)mg/3ml as ordered due to her COPD and her new diagnosis of heart failure that contributed to her shortness of breath.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/28/21 at 12:10pm revealed:
-Resident #3's Iprat-albuterol 0.5-3(2.5)mg/3ml was last filled by the pharmacy in February 2021.
-If she had not used all the medication from when it was last filled, Resident #3's Iprat-albuterol 0.5-3(2.5)mg/3ml would not be expired yet.
-If it was not documented as administered on Resident #3's eMAR, she would assume the resident had not been administered the medication and therefore it should be on hand for the resident to use.
-It was concerning that Resident #3 did not have Iprat-albuterol 0.5-3(2.5)mg/3ml on hand because she had a diagnosis of COPD and needed the medication to get relief of shortness of breath and wheezing.

Telephone interview with a clinical staff member at Resident #3's PCP office on 10/28/21 at 10:57am revealed Resident #3 needed her Iprat-albuterol 0.5-3(2.5)mg/3ml because she had a history of COPD and the resident's primary care provider (PCP) would be concerned that she did not have it available to her as ordered.

Telephone interview with Resident #3's PCP on 10/28/21 at 12:29pm revealed:
-He last saw Resident #3 on 10/21/21.
-He expected the facility to keep medications on hand for residents as ordered.
-He was concerned that the resident did not have her Iprat-albuterol 0.5-3(2.5)mg/3ml because she

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D 358	Continued From page 50 needed it to relieve her symptoms of shortness of breath and during COPD exacerbations. _____ The facility failed to ensure medications were administered as ordered. Resident #1, who was a diabetic and was ordered to receive sliding scale insulin based on his blood sugar results, had multiple occasions when the number of units of sliding scale insulin administered was adjusted by a medication aide without an physician's order resulting in the resident receiving the incorrect number of units of insulin and placing him at risk for high and low blood sugars and other adverse events related to high and low blood sugars, such as falls. Resident #3 who exhibited shortness of breath with minimal exertion, had edema in the bilateral lower extremities, and had a new diagnosis of heart failure when evaluated by her primary care provider on 10/21/21 did not receive a diuretic as ordered to treat the symptoms resulting in risk of continued and/or worsening exacerbation of symptoms. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of correction in accordance with G.S. 131D-34 on 10/28/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 12, 2021.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration	D 367		

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record (MAR) shall be accurate and include the following:
(1) resident's name;
(2) name of the medication or treatment order;
(3) strength and dosage or quantity of medication administered;
(4) instructions for administering the medication or treatment;
(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure medication administration records were complete and accurate for 1 of 3 residents sampled including medications for chronic pain control and infection (Resident #1).

The findings are:

Review of the facility's medication administration policy revealed staff members administering medications were responsible for charting the drug immediately on the resident's medication administration record.

1. Review of Resident #1's current FL-2 dated 03/26/21 revealed diagnoses included type 2 diabetes mellitus, left lower leg amputation, hypertension, and peripheral vascular disease.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 52 a. Review of Resident #1's physician order dated 07/17/21 revealed there was an order for Hydrocodone-Acetaminophen 7.5-325, take one table every 6 hours as needed for pain (Hydrocodone-Acetaminophen is a medication used to manage chronic pain). Review of Resident #1's control substance count sheet (CSCS) with a start date of 10/08/21 revealed: -Hydrocodone-Acetaminophen 7.5-325 was documented as administered on 10/11/21 at 8:00pm. -Hydrocodone-Acetaminophen 7.5-325 was documented as administered on 10/17/21 at 8:30am. -Hydrocodone-Acetaminophen 7.5-325 was documented as administered on and 10/22/21 at 8:00pm. Review of Resident #1's October 2021 electronic medication administration record (eMAR) revealed: -There was no documentation of Hydrocodone-Acetaminophen 7.5-325 being administered on 10/11/21 at 8:00pm. -There was no documentation of Hydrocodone-Acetaminophen 7.5-325 being administered on 10/17/21 at 8:30am. -There was no documentation of Hydrocodone-Acetaminophen 7.5-325 being administered on 10/22/21 at 8:00pm. Interview with Resident #1 on 10/28/21 at 12:30pm revealed: -He received his pain medication when requested. -He was on pain medication for chronic pain.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008041	A. BUILDING: _____ B. WING _____	10/28/2021

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D 367	Continued From page 53	D 367		

Refer to the interview with the medication aide (MA) on 10/28/21 at 2:20pm.

Refer to the interview with the lead MA/supervisor on 10/28/21 at 2:50pm.

Refer to the interview with the Administrator on 10/28/21 at 4:15pm.

Refer to the telephone interview with the facility's contracted primary care provider (PCP) on 10/28/21 at 12:40pm.

b. Review of Resident #1's physician order dated 08/10/21 revealed there was an order for Cephalexin 500mg, take one capsule 2 times a day for 7 days (Cephalexin is an antibiotic used to treat infection).

Review of Resident #1's August 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Cephalexin 500 mg, take one capsule two times a day with a start date of 08/11/21 and an end date of 08/18/21 scheduled for administration at 8:00am and 8:00pm.
-Cephalexin was documented as administered twice a day from 08/11/21 to 08/18/21 for a total of 8 days and 16 doses.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/28/21 at 12:11pm revealed the pharmacy received an order for Cephalexin 500 mg, take one capsule two times a day on 08/10/21 and dispensed 14 doses for a 7-day supply to start on 08/11/21.

Interview with Resident #1 on 10/28/21 at 12:30pm revealed he was unable to recall how long he was on the antibiotics in August 2021.

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D 367	Continued From page 54 Refer to the interview with the medication aide (MA) on 10/28/21 at 2:20pm. Refer to the interview with the lead MA/supervisor on 10/28/21 at 2:50pm. Refer to the interview with the Administrator on 10/28/21 at 4:15pm. Refer to the telephone interview with the facility's contracted primary care provider (PCP) on 10/28/21 at 12:40pm. c. Review of Resident #1's physician order dated 09/30/21 revealed there was an order for Bactrim DS, take 1 tablet 2 times a day for 7 days (Bactrim is an antibiotic used to treat infection). Review of Resident #1's October 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Bactrim DS, take 1 tablet 2 times a day with a start date of 10/01/21 and an end date of 10/08/21 scheduled for administration at 8:00am and 8:00pm. -Bactrim DS was documented as administered twice a day from 10/01/21 to 10/08/21 for a total of 8 days and 16 doses. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/28/21 at 12:11pm revealed the pharmacy received an order for Bactrim DS, take one tablet two times a day on 09/30/21 and dispensed 14 doses for a 7-day supply to start on 10/01/21. Interview with Resident #1 on 10/28/21 at 12:30pm revealed he was unable to recall how long he was on the antibiotics earlier this month	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 55 (October 2021). Refer to the interview with the medication aide (MA) on 10/28/21 at 2:20pm. Refer to the interview with the lead MA/supervisor on 10/28/21 at 2:50pm. Refer to the interview with the Administrator on 10/28/21 at 4:15pm. Refer to the telephone interview with the facility's contracted primary care provider (PCP) on 10/28/21 at 12:40pm. _____ Interview with the medication aide (MA) on 10/28/21 at 2:20pm revealed: -Medication should be documented on the electronic medication administration record (eMAR) when administered. -The medication labels were scanned using a handheld scanner that would transfer over to the eMAR and then the MA was responsible for ensuring that the medication was signed off on the eMAR after administration. -The lead MA/supervisor or the Administrator was responsible for approving medication orders on the electronic medication administration record (eMAR). Interview with the lead MA/supervisor on 10/28/21 at 2:50pm revealed: -She or the Administrator were responsible for reviewing medications transcribed by the pharmacy on the eMAR. -Once she reviewed the medication to ensure that it was the correct resident, medication, dosage, and time she would approve the medication so that it was available to administer on the eMAR. -The pharmacy entered stop dates on the	D 367		

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D 367	Continued From page 56 medications, and it was her responsibility and the Administrators to ensure that they were correct. -She was not sure why the eMAR was not correct. Interview with the Administrator on 10/28/21 at 4:15pm revealed: -The lead MA/supervisor and herself were responsible for approving medications on the eMAR after the pharmacy enters the orders. -There is no current audit process in place to review accuracy of eMAR. -She was not sure why the eMARs were not correct. Telephone interview with the facility's contracted primary care provider (PCP) on 10/28/21 at 12:40pm: -He expected the eMAR to accurately reflect what medications the resident received. -He utilized the eMAR to help determine pain control and other medication monitoring which was why it was important that the eMAR be complete and accurate.	D 367		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure infection	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 371	Continued From page 57 control measures were implemented during the morning medication pass on 10/28/21 by 1 of 1 medication aide observed who failed to wash or sanitize their hands between administering medication to multiple residents, checking a resident's fingerstick blood sugar, and administering insulin. The findings are: Observation of the medication aide (MA) administering morning medications in the medication room on 10/28/21 from 8:00am to 8:27am revealed: -There was no hand sanitizer on the medication cart. -The MA washed her hands with soap and water in the staff bathroom located in the medication room at 8:05am. -The MA donned gloves at 8:06am and prepared a resident's medications in the medication room. -The resident swallowed her medications at 8:08am. -The MA kept the same gloves on and did not perform hand hygiene before preparing the next resident's medication. -The second resident was handed his medication by the MA and he swallowed his medications at 8:10am. -The MA checked the second resident's fingerstick blood sugar. -The MA discarded her gloves and donned a new pair of gloves at 8:11am. -She did not wash her hands or use hand sanitizer prior to donning the new pair of gloves. -The MA administered an insulin injection to the second resident at 8:14am. -The MA removed her gloves and put on a new pair of gloves to prepare a third resident's medications at 8:18am.	D 371		

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D 371	Continued From page 58	D 371		

-She did not wash her hands or use hand sanitizer prior to donning a new pair of gloves.
-After administering the third resident's medications, she removed her gloves.
-The MA asked a co-worker to hand her the hand sanitizer that was on the windowsill of the medication room at 8:22am and performed hand hygiene.

Interview with the MA performing the morning medication pass on 10/28/21 at 8:44am revealed:
-She usually washed her hands after each resident when administering medications in the medication room.
-There was a co-worker in the staff bathroom, so she was not able to wash her hands with soap and water after each resident that morning (10/28/21).
-Hand sanitizer should be on the medication cart at all times, but someone must have moved.
-She did not recall not performing hand hygiene between the three residents observed this morning.
-She was aware that hand hygiene should be performed after each resident using soap and water or hand sanitizer.

Interview with the Administrator on 10/28/21 at 4:15pm revealed:
-She expected staff to perform hand hygiene after performing resident care, including medication administration.
-She expected staff to always keep hand sanitizer on the medication cart.
-She was concerned that staff not performing proper hand hygiene could result in cross-contamination or risk for infection.

Telephone interview with the facility's contracted primary care provider on 10/28/21 at 12:40pm

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D 371	Continued From page 59 revealed he expected facility staff to perform proper hand hygiene during medication administration to reduce the risk of infection and the spread of communicable diseases.	D 371		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure readily retrievable records that accurately reconciled the disposition and administration of controlled substances for 1 of 2 residents sampled (Resident #1) for a medications used to treat pain and anxiety. The findings are: Review of Resident #1's current FL-2 dated 03/26/21 revealed diagnoses included type 2 diabetes mellitus, left lower leg amputation, hypertension, and peripheral vascular disease. 1. Review of Resident #1's physician's orders dated 07/17/21 revealed there was an order for Hydrocodone-Acetaminophen 7.5-325, take one tablet every 6 hours as needed pain (Hydrocodone-Acetaminophen is a medication	D 392		

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D 392	Continued From page 60 used to control chronic pain). Observation of the Resident #1's medications on hand on 10/27/21 at 4:25pm revealed there were 51 of 62 Hydrocodone-Acetaminophen 7.5-325 tablets from the supply dispensed. Review of Resident #1's controlled substances (CS) log for Hydrocodone-Acetaminophen 7.5-325 with a start date of 07/20/21 and an end date of 10/05/21 revealed: -There was no year on 58 of the 60 dates documented as administered on the CS log entries. -On the 08/16/21 entry, "2" was documented for the time without differentiating AM or PM. -On the 08/21/21 entry, "10" was documented for the time without differentiating AM or PM. -On the 09/01/21 entry, there was no time or staff signature documented. -On the 09/03/21 entry, there was no time documented. -On the 09/04/21 entry, there was no time documented. -On the last line of the CS log, when there was one dose remaining, there was no date, time or signature documented. Review of Resident #1's CS log for Hydrocodone-Acetaminophen 7.5-325 with a start date of 10/08/21 until 10/22/21 revealed: -There was no year on 2 of the 5 dates documented as administered on the CS log entries. -On the 10/13/21 entry, "2:15" was documented for the time without differentiating AM or PM. -There was one entry, between 10/13/21 and 10/17/21, that there was just a signature without a date or time documented.	D 392		

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D 392	Continued From page 61 Interview with Resident #1 on 10/28/21 at 12:30pm revealed staff administered him pain medication when he requested for chronic pain. Refer to the interview with the medication aide on 10/28/21 at 2:20pm. Refer to the interview with the lead MA/supervisor on 12/28/21 at 2:40pm. Refer to the interview with the Administrator on 10/28/21 at 4:15pm. 2. Review of Resident #1's physician's orders dated 07/17/21 revealed: -There was an order for Ativan 1mg at bedtime (Ativan is used to treat anxiety). -There was an order for Ativan 0.5mg twice a day as needed for anxiety. Observation of the Resident #1's medications on hand on 10/27/21 at 4:25pm revealed: -There were 24 tablets remaining of the Ativan 1mg from the supply dispensed. -There were 70 tablets remaining of the Ativan 0.5mg from the supply dispensed. Review of Resident #1's controlled substance (CS) log for Ativan 0.5mg every 6 hours as needed with a start date of 05/23/21 until 08/22/21 revealed: -There was no year on 32 of the 32 dates documented as administered on the CS log entries. -Staff was documenting the bedtime dose of 1mg on the as needed 0.5mg dose from 07/16/21 until 08/22/21. Interview with the Administrator on 10/28/21 at 9:30am revealed she was not able to locate	D 392		

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D 392	Continued From page 62 Resident #1's CS log for Ativan 1mg at bedtime dose for the time period between 08/22/21 and 10/20/21. Review of Resident #1's CS log for Ativan 1mg at bedtime starting 10/20/21 and ending 10/26/21 revealed: -There was no year on 7 of the 7 dates on the CS long entries. Refer to the interview with the medication aide on 10/28/21 at 2:20pm. Refer to the interview with the lead MA/supervisor on 12/28/21 at 2:40pm. Refer to the interview with the Administrator on 10/28/21 at 4:15pm. _____ Interview with the medication aide on 10/28/21 at 2:20pm revealed the controlled substance (CS) log should be completed entirely and accurately including year and time of administration to include AM or PM. Interview with the lead MA/supervisor on 12/28/21 at 2:40pm revealed: -She had not filled out the CS log completely on occasion because she would be called away or forget to complete the documentation. -The CS log should be completed entirely and accurately including year and time of administration to include AM or PM. -There was no audit process in place to review the CS logs but there was a shift to shift count documented after counting controlled substances on the medication cart. Interview with the Administrator on 10/28/21 at 4:15pm revealed:	D 392		

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D 392	Continued From page 63 -The CS log should be completed entirely and accurately including year and time of administration to include AM or PM. -She was not aware that Resident #1's CS logs were not complete or accurate. -There was currently no audit process in place to ensure CS logs were complete and accurate.	D 392		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to health care and medication administration. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up for 2 of 3 sampled residents related to blood sugars outside of ordered parameters and notification to the primary care provider (#3) and a required follow-up appointment after a hospital visit (#1). [Refer to Tag D0273, 10A NCAC 13F .0902(b) Health Care. (Type B Violation)] 2. Based on observations, interviews, and record	D912		

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D912	Continued From page 64 reviews the facility failed to ensure medications were administered as ordered for 4 of 5 sampled residents (#1, #3, #4, and #5) including errors with insulin (#1, #4, and #5) and a diuretic and nebulizer (#3). [Refer to Tag D0358, 10A NCAC 13F .1004(a) Medication Administration. (Type B Violation)]	D912		