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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual survey on February 15-16, 2022 with a telephone exit on February 16, 2022. | D 000 | | |
| D 354 | 10A NCAC 13F .1003 (c) Medication Labels<br><br>10A NCAC 13F .1003 Medication Labels<br><br>(c) The facility shall assure the container is relabeled by a licensed pharmacist or a dispensing practitioner at the refilling of the medication when there is a change in the directions by the prescriber. The facility shall have a procedure for identifying direction changes until the container is correctly labeled. No person other than a licensed pharmacist or dispensing practitioner shall alter a prescription label.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure the medication containers had correct labels for 1 of 5 sampled residents (#1) related to Warfarin, a medication used to thin blood to prevent clotting (Resident #1) and 1 of 7 residents (#6) observed during the medication pass related to an insulin pen used for elevated blood glucose.<br><br>The findings are:<br><br>1. Review of Resident #1's current FL2 dated | D 354 | | |

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revealed diagnosis included anemia and hypertension.

Review of Resident #1's Register revealed an admission date of 08/27/21.

Review of Resident #1's physician orders dated 08/30/21 revealed:
-The resident was diagnosed with atrial fibrillation.
-There was an order for Warfarin 5mg one tablet daily, recheck the international normalized ratio (INR) in one week, (a blood test to determine if the blood is clotting normally).

Review of Resident #1's physician's order dated 09/08/21 revealed there was an order for Warfarin 5mg, take one and one half tablets (7.5mg), once daily, recheck INR in one week.

Review of Resident #1's physician's orders from 09/18/21 through 02/16/22 revealed:
-There were alternating Warfarin orders of 5mg and 2.5mg tablets once daily, recheck INR weekly.
-There were no subsequent orders for Warfarin 7.5mg daily.

Observation of Resident #1's medications available for administration on 02/15/22 at 3:48pm revealed:
-There was one medication bottle labeled Warfarin 2.5 mg tablets, take one tablet daily, 45 tablets dispensed on 10/13/21 with 32 tablets remaining.
-There was one medication bottle labeled Warfarin 5mg take one and one half tablets to equal 7.5 mg daily, 45 tablets dispensed on 02/05/22 with 43 tablets remaining.
-There was no change of direction sticker or indication the label was changed based on the

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current Warfarin order.

Review of Resident #1's December 2021 through February 15, 2022 electronic medication administration record (eMAR) revealed there were entries for Warfarin 2.5mg daily alternating with Warfarin 5mg daily to be administered at 5:00pm.

Telephone interview with Resident #1's pharmacist on 02/15/22 at 3:35pm revealed:
-This pharmacy filled Resident #1's medications and a family member delivered the prescriptions to the resident.
-On 09/16/21, Resident #1's cardiologist sent an order for Warfarin 5mg, one and one half tablets to be administered daily(7.5mg), and a 30 day supply of 45 tablets was dispensed and given to the family member.
-On 12/03/21 and 02/05/22, the pharmacist dispensed an additional 30 day supply of 45 pills for Warfarin 5mg, 7.5mg daily.
-He had not received any additional orders from the prescribing physician since the 09/16/21 prescription for Warfarin 5mg, one and a half tablets to equal 7.5mg daily.
-He had not received any new orders from Resident #1's facility since the Warfarin order of 7.5mg daily.

Interview with a representative from the facility's contracted pharmacy on 02/15/22 at 3:15pm revealed:
-Resident #1's medications were profiled and entered on the eMAR but dispensed through another pharmacy.
-The facility staff received all physician orders and faxed them to the pharmacy staff.
-The pharmacy staff entered new orders on the eMAR and discontinued medication orders.

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| D 354 | Continued From page 3<br>-The pharmacy medication profile for Resident #1 listed the current Warfarin order as of 02/15/22 as Warfarin 2.5mg to be administered on 02/10/22, 02/12/22, 02/13/22 and 02/15/22, and Warfarin 5mg to be administered on 02/11/22, 02/14/22 and 02/16/22, recheck INR in 1 week.<br>-It was the responsibility of the facility to place a direction change label on a medication bottle or bubble pack when a medication order changed.<br><br>Interview with two second shift medication aides (MAs) on 02/15/22 at 4:10pm revealed:<br>-When the medication label does not match the eMAR entry for a resident's medication order, the MAs should contact the RCC or the physician for clarification.<br>-It was the responsibility of the MA on the cart to place a direction change label on medication bottles and bubble packs when a medication order changed.<br>-Neither had remembered to place the direction change label on the medication bottle.<br>-The MAs looked at the eMAR when administering medications and did not observe the label on Resident #1's Warfarin bottle.<br>-It was the MAs responsibility to notify the RCC.<br><br>Interview with the RCC and the Administrator on 02/16/22 at 12:30pm revealed:<br>-The RCC was aware Resident #1's Warfarin order was no longer 7.5mg daily.<br>-It was her responsibility as well as the MAs to place a change of direction sticker on medication bottles and bubble packs when the orders changed.<br>-It was the RCC's responsibility to notify the dispensing pharmacy of all of Resident #1's Warfarin orders.<br>-The RCC had not faxed Warfarin orders when they changed to the dispensing pharmacy. | D 354 | | |

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| D 354 | Continued From page 4<br>-The Administrator was not aware the label on Resident #1's Warfarin medication bottle reflected a discontinued order from 09/16/21.<br>-It was the responsibility of the RCC to ensure medications were labeled in accordance with the current order, or a change of direction sticker placed on the medication container.<br><br>2. Review of Resident #6's current FL2 dated 03/26/21 revealed:<br>-Diagnosis included Diabetes Mellitus Type 2.<br>-There was an order for NovoLog Flexpen U-100, inject 6 units before meals, hold for blood glucose less than 100.<br><br>Review of physician's order dated 12/23/21 revealed:<br>-There was an order to discontinue Novolog Flexpen 6 units before meals, hold for blood glucose less than 100.<br>-There was an order to start Novolog Flexpen U-100 8 units before meals, hold for blood glucose less than 100.<br><br>Observation of Resident #6 during the medication pass on 02/15/22 at 11:25am revealed:<br>-The MA administered the fingerstick blood glucose (FSBS) test, which registered a blood sugar of 159.<br>-The MA removed the NovoLog Flexpen from the medication cart.<br>-The Flexpen was in a plastic bag with the pharmacy label affixed to the bag.<br>-The label read NovoLog Flexpen U-100, inject 6 units before meals, hold for blood glucose less than 100.<br>-There was no change of direction sticker or indication the label was inaccurate based on the current Novolog insulin order of 8 units before meals, hold for blood glucose less than 100. | D 354 | | |

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| D 354 | Continued From page 5<br><br>Review of Resident #1's December 23, 2021 through February 15, 2022 electronic medication administration record (eMAR) revealed there were entries for Novolog Flexpen U-100 8 units before meals, hold for blood glucose less than 100.<br><br>Interview with the Resident Care Coordinator (RCC) on 02/15/22 at 11:35am revealed:<br>-If there was a change in directions ordered by the physician for an existing medication, the MAs were to place a direction change sticker on the bubble pack or medication bottle to refer to the eMAR for new directions.<br>-Direction change labels were located in the medication room and should be on each medication cart.<br>-It was the policy of the facility to affix direction change stickers on the bubble packs of medications when their orders changed.<br>-She knew Resident #6's insulin order had changed and she did not follow the facility policy to place a change of direction sticker on the Novolog Flexpen bag.<br><br>Interview with the Administrator on 02/16/22 at 12:30pm revealed:<br>-She relied on the RCC and the MAs to follow the process and procedures for correct medication administration.<br>-It was her expectation the medications would be correctly labeled for administration to the residents.<br>-The MAs should be referring to the directions on the medication label and the eMAR before administering medications.<br>-She did not know Resident #6 had a medication that was incorrectly labeled. | D 354 | | |

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| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#1) related to Warfarin.<br><br>The findings are:<br><br>Review of Resident #1's current FL2 dated 08/24/21 revealed diagnoses included anemia, impaired fasting glucose and hypertension.<br><br>Review of Resident #1's Register revealed an admission date of 08/27/21.<br><br>Review of Resident #1's physician's orders dated 08/30/21 revealed:<br>-The resident was diagnosed with atrial fibrillation.<br>-There was an order for Warfarin 5mg, a medication used to thin the blood to prevent blood clots and strokes in residents with a diagnosis of atrial fibrillation, one tablet daily, recheck the international normalized ratio (INR), (a blood test to determine if the blood is clotting | D 358 | | |

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| D 358 | Continued From page 7<br>normally) in one week .<br><br>Review of Resident #1's physician's orders dated 09/08/21 revealed there was an order for Warfarin 5mg, take one and one half tablets (7.5mg), once daily recheck INR in one week.<br><br>Review of Resident #1's physician's orders from 09/18/21 through 12/01/21 revealed there were alternating Warfarin orders of 5mg and 2.5mg tablets once daily, recheck INR weekly.<br><br>Review of Resident #1's record for physician's orders from 12/01/21 through 12/31/21 revealed:<br>-There was an order dated 12/01/21 for Warfarin 2.5mg to be administered on 12/01/21, 12/03/21, 12/05/21, 12/06/21, and Warfarin 5mg to be administered on 12/02/21, 12/04/21 and 12/07/21, recheck INR in one week (12/07/21).<br>-There was an order dated 12/08/21 for Warfarin 2.5 mg to be administered on 12/08/21, 12/10/21, and 12/12/21 through 12/15/21, and Warfarin 5mg to be administered on 12/09/21, 12/11/21 and 12/16/21, recheck INR in one week (12/16/21).<br>-There was an order dated 12/17/21 for Warfarin 5mg to be administered on 12/17/21, 12/19/21, 12/20/21 and 12/22/21, and Warfarin 2.5mg to be administered on 12/18/21 and 12/21/21.<br>-There was no documentation of physician's orders for Warfarin in Resident #1's record from 12/22/21 through 12/31/21.<br><br>Review of Resident #1's December 2021 electronic Medication Administration Record (eMARs) revealed:<br>-There was an entry dated 12/01/21 for Warfarin 2.5mg to be administered at 5:00pm on 12/01/21, 12/03/21, 12/05/21, 12/06/21 and 12/07/21, recheck INR in one week (12/08/21). | D 358 | | |

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| D 358 | Continued From page 8<br>-Warfarin 2.5mg was documented as administered daily on 12/01/21, 12/03/21, 12/05/21, 12/06/21 and 12/07/21 at 5:00pm.<br>-There was an entry dated 12/01/21 for Warfarin 5mg to be administered on 12/02/21 and 12/04/21.<br>-Warfarin 5mg was documented as administered on 12/02/21 and 12/04/21 at 5:00pm.<br>-There was an entry dated 12/08/21 for Warfarin 2.5 mg to be administered on 12/08/21, 12/10/21, and 12/12/21 through 12/15/21, recheck INR in one week.<br>-Warfarin 2.5mg was documented as administered on 12/08/21, 12/10/21, and 12/12/21 through 12/15/21 at 5:00pm.<br>-There was an entry dated 12/08/21 for Warfarin 5mg to be administered on 12/09/21, 12/11/21 and 12/16/21 .<br>-Warfarin 5mg was documented as administered on 12/09/21, 12/11/21 and 12/16/21 at 5:00pm.<br>-There was an entry dated 12/17/21 for Warfarin 2.5mg to be administered on 12/18/21 and 12/21/21 at 5:00pm.<br>-Warfarin 2.5mg was documented as administered on 12/18/21 and 12/21/21 at 5:00pm.<br>-Warfarin was not documented as administered from 12/23/21 through 12/30/21 at 5:00pm.<br>-There were 8 out of 31 opportunities, Resident #1's Warfarin was not documented as administered from 12/23/21 through 12/30/21 at 5:00pm.<br><br>Review of Resident #1's record for physician's orders from 01/01/22 through 01/31/22 revealed:<br>-There was an order dated 12/30/21 for Warfarin 5mg to be administered from 12/31/21 through 01/06/22, recheck INR in one week (01/06/22).<br>-There was no documentation of INR results on 01/06/22 through 01/27/22. | D 358 | | |

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-There was no documentation of any physician's orders for Warfarin from 01/07/22 through 01/27/22.
-The resident's INR results were not documented from 01/06/22 through 01/26/22.
-There was documentation Resident #1's INR was obtained on 01/27/22 and the results were 2.8.
-There was a physician's order on 01/27/22 for Warfarin 2.5mg to be administered on 01/28/22, 01/30/22, 01/31/22, and Warfarin 5mg on 01/29/22 and 2/01/22 through 02/03/22 at 5:00pm, recheck INR in one week (02/04/22).

Review of Resident #1's January 2022 eMAR revealed:
-There was an entry dated 01/01/22 through 01/06/22 for Warfarin 5mg to be administered daily, recheck INR in one week (01/13/22).
-Warfarin 5mg was documented as administered from 01/01/22 through 01/27/22 at 5:00pm.
-The entry dated 12/31/21 for Warfarin 5mg daily continued from 01/06/22 through 01/27/22 at 5:00pm, with no new orders entered.
-There was an entry dated 01/27/22 through 01/31/22 for Warfarin 5mg to be administered daily, recheck INR in 1 week (02/04/22).
-There were 15 out of 31 opportunities, Warfarin 5mg was administered to Resident #1 without a physician's order or INR results.
-There were 3 out of 31 opportunities Warfarin 2.5mg was ordered by the physician and Warfarin 5mg was documented as administered on 01/28/22, 01/30/22 and 01/31/22.

Review of Resident #1's physician's order dated 02/04/22 through 02/10/22 revealed.
-There was an order on 02/04/22 for Warfarin 2.5mg to be administered on 02/04/22 and 02/10/22 and Warfarin 5.0 mg to be administered

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on 02/05/22 through 02/09/22, recheck INR in 1 week (02/10/22).
-The INR results on 02/10/22 were 3.9.
-There was an order on 02/10/22 for Warfarin 2.5mg to be administered on 02/10/22, 02/12/22, 02/13/22 and 02/15/22, and Warfarin 5mg to be administered on 02/11/22, 02/14/22 and 02/16/22, recheck INR in 1 week (02/17/22).

Review of Resident #1's February 2022 eMAR revealed:
-There was an entry dated 01/28/22 through 02/04/22 for Warfarin 5mg to be administered on 02/01/22 and 02/03/22.
-Warfarin 5mg was documented as administered on 02/01/22, 02/02/22 and 02/03/22.
-There was an entry dated 01/28/22 for Warfarin 2.5mg to be administered on 02/02/22.
-There was no documentation Warfarin 2.5mg was administered on 02/02/22 at 5:00pm.
-There was an entry dated 02/04/22 for Warfarin 2.5mg to be administered on 02/04/22 and 02/10/22 at 5:00pm.
-On 02/04/22 through 02/06/22 there was no documentation Warfarin 2.5mg was administered to Resident #1.
-There was documentation Warfarin 2.5mg was administered on 02/10/22 at 5:00pm
-There was an entry dated 02/04/22 for Warfarin 5mg to be administered on 02/05/22 through 02/09/22 at 5:00pm.
-There was no documentation Warfarin 5mg was administered on 02/05/22 or 02/06/22 at 5:00pm.
-There was an entry dated 02/10/22 for Warfarin 2.5mg to be administered on 02/10/22, 02/12/22, 02/13/22 and 02/15/22, and Warfarin 5mg to be administered on 02/11/22, 02/14/22 and 02/16/22, recheck the INR in 1 week (02/17/22).
-There was no documentation Warfarin was administered from 02/11/22 through 02/13/22.

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-There was documentation Warfarin 2.5 mg was administered instead of the ordered dosage of Warfarin 5mg on 02/07/22 and 02/14/22.
-There were 6 out of 16 opportunities Resident #1's Warfarin was not documented as administered.
-There were 2 out of 16 opportunities, Resident #1's Warfarin was administered as 2.5mg and not Warfarin 5mg as ordered.

Observation of Resident #1's medications available for administration on 02/15/22 at 3:48pm revealed:
-There was one medication bottle labeled Warfarin 2.5 mg tablets, take one tablet daily with 45 tablets dispensed on 10/13/21 and 32 tablets remaining.
-There was one medication bottle labeled Warfarin 5mg take one and one half tablets to equal 7.5 mg daily with 45 tablets dispensed on 02/05/22 and 43 tablets remaining.

Interview with the pharmacist from the facility's contracted pharmacy on 02/15/22 at 3:15pm revealed:
-Resident #1's medications were profiled and entered on the eMAR but dispensed through another pharmacy.
-The facility staff received all physician orders and faxed them to the pharmacy staff.
-The pharmacy staff entered new orders on the eMAR and discontinued medication orders.
-The following were Resident #1's Warfarin orders faxed from the facility in December 2021:
-There was an order dated 12/01/21 for Warfarin 2.5mg to be administered on 12/01/21, 12/03/21, 12/05/21, 12/06/21, and Warfarin 5mg to be administered on 12/02/21, 12/04/21 and 12/07/21, recheck INR in one week (12/07/21);
- There was an order dated 12/08/21 for Warfarin

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| D 358 | Continued From page 12<br>2.5 mg to be administered on 12/08/21, 12/10/21, and 12/12/21 through 12/15/21, and Warfarin 5mg to be administered on 12/09/21, 12/11/21 and 12/16/21, recheck INR in one week (12/16/21);<br>- There was an order dated 12/17/21 for Warfarin 5mg to be administered on 12/17/21, 12/19/21, 12/20/21 and 12/22/21, and Warfarin 2.5mg to be administered on 12/18/21 and 12/21/21.<br>-There were no physician orders for Resident #1's Warfarin in the resident's record from 12/22/21 through 12/31/21.<br>-The following were Resident #1's Warfarin orders faxed from the facility in January 2022:<br>-There was an order dated 12/30/21 for Warfarin 5mg to be administered from 12/31/21 through 01/06/22, recheck INR in one week (01/06/22);<br>-There was no documentation of any physician's orders for Warfarin from 01/07/22 through 01/31/22.<br>-The following were Resident #1's Warfarin orders faxed from the facility in February 2022:<br>-There were no new Warfarin orders from 02/01/22 through 02/03/22;<br>-There was an order dated 02/04/22 for Warfarin 2.5mg to be administered on 02/04/22 and 02/10/22 and Warfarin 5mg to be administered on 02/05/22 through 02/09/22, recheck INR in 1 week (02/17/22);<br>-There was an order dated 02/10/22 for Warfarin 2.5mg to be administered on 02/10/22, 02/12/22, 02/13/22 and 02/15/22, and Warfarin 5mg to be administered on 02/11/22, 02/14/22 and 02/16/22, recheck INR in 1 week (02/17/22).<br><br>Telephone interview with a pharmacist from Resident #1's pharmacy on 02/15/22 at 3:35pm revealed:<br>-This pharmacy filled Resident #1's medications and a family member delivered the prescriptions | D 358 | | |

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to the resident.
-On 12/03/21 and 02/05/22, the pharmacist dispensed a 30 day supply of 45 pills for Warfarin 5mg, 7.5mg daily.
-He had not received any additional orders from the prescribing physician since the 09/16/21 prescription for Warfarin 5mg, one and a half tablets to equal 7.5mg daily.
-He had not received any new physician's orders from Resident #1's facility to change the Warfarin order of 7.5mg daily.

Interview with two second shift medication aides (MAs) on 02/15/22 at 4:10pm revealed:
-They administered Resident #1's Warfarin at 5:00pm.
-They knew her Warfarin orders changed frequently but they administered the current dosage that was on the eMAR.
-They only administered medications as entered on the eMAR.
-They did not fax new orders to the pharmacy.
-They did not know why there was no documentation of administration of Resident #1's Warfarin on 12/23/21 through 12/30/21, on 02/04/22 through 02/06/22 and 02/11/22 through 02/13/22.
-They always administered the Warfarin as scheduled.

Interview with the Resident Care Coordinator (RCC) on 02/15/22 at 4:15pm and 02/16/22 at 12:05pm revealed:
-The Home Health Nurse (HHN) obtained Resident #1's INR as ordered by the physician.
-The HHN reported the INR findings to the physician, and he ordered whatever changes in the Warfarin administration he felt necessary, and sent the new orders to the facility.
-She faxed the new order to the contracted

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pharmacy staff who entered the order on the eMAR.
-She did not enter orders on the eMAR.
-She knew Resident #1's Warfarin orders had changed since 09/16/21, but had not faxed the dispensing pharmacist the new orders as they were sent from the physician.
-She was not sure why she had not faxed the dispensing pharmacy the new Warfarin orders from Resident #1's physician.
-She did not know why the MAs would not have documented administering Resident #1's Warfarin from 12/23/21 through 12/30/21 at 5:00pm, on 02/04/22 through 02/06/22 and 02/11/22 through 02/13/22.
-She tried to review the eMARs monthly, but had not been able to review all the residents' eMARs in several months.
-It was her responsibility to ensure medications were administered as ordered by the physician.
-She knew the HHN had discharged Resident #1 from services on 01/06/22 but she thought they had picked her up again immediately.
-She did not know Resident #1's INR was not obtained from 01/06/22 through 01/27/22.
-She did not know the current orders on the eMARs from 01/13/22 through 01/27/22 were not ordered by the physician.
-The Warfarin 5mg to be administered once daily continued as an active order from 01/13/22 until 01/31/22 since no additional orders were sent to the pharmacy.
-The physician contacted the HHN after Resident #1's INR was obtained and reported the new Warfarin orders.
-The HHN or the physician sent the results of the INR and the new Warfarin orders to the facility.
-She should have realized there were no new orders and contacted the HHN or the prescribing physician.

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| D 358 | Continued From page 15<br><br>Telephone interview with Resident #1's responsible family member on 02/16/22 at 9:05am revealed:<br>-Resident #1 had a stroke in July 2021.<br>-The physician wanted to prescribe Eliquis, a blood thinning medication, to prevent future clotting and risk of another stroke.<br>-The family requested Warfarin to be substituted for Eliquis due to financial concerns.<br>-She delivered Resident #1's medications from the pharmacy to the facility.<br>-As the responsible family member, she had access to the resident's physician portal and could follow her INR testing and medication changes.<br>-In January 2022, Resident #1's insurance changed and the HHN did not have an order to continue services under the new insurance.<br>-The family member was sick during this time and did not follow up with the facility or the HHN to ensure the HHN was obtaining the INR and new orders from the physician.<br><br>Interview with the HHN on 02/15/22 at 4:00pm and 02/16/22 at 9:15am revealed:<br>-The HHN obtained Resident #1's INR weekly, or as ordered by the physician.<br>-She sent the INR results and received order changes from the physician.<br>-The HHN would call the RCC and report any new orders and the physician faxed a copy of the orders to the facility.<br>-Resident #1's INR varied from 1.2 to 3.4 during the month of December 2021.<br>-The therapeutic range for a resident's INR was 2.0-3.0.<br>-The orders from the physician from 12/23/21 through 12/30/21 were Warfarin 5mg to be administered on 12/23/21, 12/25/21, 12/26/21, | D 358 | | |

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| D 358 | Continued From page 16<br>12/28/21 through 12/30/21, and Warfarin 2.5mg on 12/24/21 and 12/27/21 recheck INR on 12/30/21.<br>-These INR results were documented by the HHN and verbalized to the RCC at the facility on 12/23/21.<br>-The Warfarin orders from the physician from 12/31/21 through 01/06/22 were: Warfarin 5mg to be administered from 12/30/21 through 01/06/22, and were documented as transmitted to the RCC verbally on 12/31/21.<br>-HH discharged Resident #1 on 01/06/22 due to changes in her insurance.<br>-Both the physician and the RCC were notified of the discharge by the HHN on 01/06/22 by phone.<br>-The physician ordered Warfarin 5mg on 01/06/22 to be administered until INR was rechecked in a week (01/13/22).<br>-A start of care date under Resident #1's new insurance was ordered by the PCP on 01/27/22.<br>-Resident #1's INR was obtained by the HHN on 01/27/22 and the new physician orders were: Warfarin 2.5mg on 01/28/22, 01/30/22 and 02/02/22, and Warfarin 5mg on 01/29/22, 02/01/22 and 02/03/22.<br>-The INR results on 01/27/22 was 2.8.<br>-Resident #1's INR was obtained by the HHN on 02/04/22 and the new physician orders were for Warfarin 2.5mg to be administered on 02/04/22 and 02/10/22 and Warfarin 5mg to be administered on 02/05/22 through 02/09/22, recheck INR in 1 week (02/10/22).<br>-INR results on 02/04/22 was 4.4.<br>-Resident #1's INR was obtained by the HHN on 02/10/22 and the new physician orders were for: Warfarin 2.5mg on 02/10/22, 02/12/22, 02/13/22, 02/15/22, and Warfarin 5mg on 02/11/22 and 02/14/22.<br>-The INR results on 02/10/22 was 3.9. | D 358 | | |

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| D 358 | Continued From page 17<br><br>Interview with Resident #1 on 02/16/22 at 10:45am revealed:<br>-She thought the staff administered the Warfarin medication before dinner at night.<br>-She was not sure if there were times Warfarin was not administered.<br>-She did not know the HHN had not obtained her INR for several weeks in January 2022.<br>-She had some bruising on her left arm but could not remember anytime lately if she had bumped her arm or did not feel well.<br><br>Interview with the Nurse Manager (RN) at Resident #1's physician's office on 02/16/22 at 3:10pm revealed:<br>-Resident #1 had a diagnosis of atrial fibrillation and had a stroke in July of 2021.<br>-On 01/06/22, the HHN reported Resident #1's INR was 1.8.<br>-The physician ordered Warfarin 5mg every day and recheck the INR in a week.<br>-This order was communicated by phone to the HHN who was responsible for Resident #1's blood work for the INRs.<br>-There was no documentation the order was sent to the facility.<br>-On 01/27/22 was the next time a report for Resident #1's INR was received.<br>-The INR was 2.8 but it was "frightening" that the INR was not monitored from 01/06/22 through 01/27/22.<br>-It was also concerning that the Warfarin was not documented as administered for 8 days in December 2021 and 6 days in February 2022.<br>-Warfarin was not ordered to be held from 12/23/21 through 12/30/21 or from 02/11/22 through 02/13/22.<br>-When a resident's blood was too thick, they were at risk for a stroke, and if the blood was too thin there could be an internal bleed. | D 358 | | |

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| D 358 | Continued From page 18<br>-The aim was to keep the INR within therapeutic range (2.0-3.0) by careful dosing of Warfarin and a steady diet of green vegetables.<br>-It was very concerning that Resident #1 went 2 and one half weeks without the INR checked and multiple documentations of Warfarin not documented as administered.<br><br>Interview with the Administrator on 02/16/22 at 12:30pm revealed:<br>-The RCC was responsible for the cart audits, reviews of the eMARs and faxing new orders to the pharmacy.<br>-Over the Christmas and New Year's holidays and through February 2022 the facility had been short staffed and the RCC was not able to perform all her duties.<br>-She did not know Resident #1's insurance had changed and the HHN had discharged her from services.<br>-She did not know Resident #1's INR had not been obtained from 01/06/22 through 01/27/22.<br>-She did not know there was no documentation of the resident receiving Warfarin from 12/23/21 through 12/30/21 or from 02/11/22 through 02/13/22.<br>-She did not know the resident received 5mg of Warfarin daily from 01/13/22 through 01/30/22 without physician orders.<br>-She expected the RCC and the MAs to report to her when medications were not administered and orders not received.<br><br>_____<br>The facility failed to ensure medications were administered as ordered for 1 of 5 residents (Resident #1) who had an order for Warfarin to be administered daily due to a recent stroke and a diagnosis of atrial fibrillation. Warfarin was not documented as administered from 12/23/21 through 12/30/21 or from 02/11/22 through | D 358 | | |

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| D 358 | Continued From page 19<br>02/13/22 and was administered without an INR test results or a physician's order from 01/13/22 through 01/27/22. This failure was detrimental to the health, safety and welfare of the resident which constitutes a Type B Violation.<br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/15/22 for this violation.<br><br>THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 2, 2022 | D 358 | | |
| D912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration.<br><br>The findings are:<br><br>1. Based on observation, interview and record review, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#1) related to Warfarin, a medication used to thin the blood to prevent blood clots and | D912 | | |

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| D912 | Continued From page 20<br>strokes in residents with a diagnosis of atrial fibrillation.[Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. | D912 | | |