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SPRING ARBOR OF KINSTON	3207 CAREY ROAD KINSTON, NC 28504

(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 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 06/08/22 to 06/09/22.	{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 notfy the primary care provider (PCP) notification for 2 of 5 sampled residents (#3 and #5) in which a resident was injured from a fall and required a follow-up appointment (#5), a resident had a change in condition (#3), and for finger stick blood sugars (#3) and blood pressures (#5) that were outside of ordered parameters. The findings are: 1. Review of Resident #5's current FL-2 dated 11/10/21 revealed diagnoses were not included on the document. Review of Resident #5's physician orders dated 01/14/22 revealed diagnoses included dizziness and unsteadiness on feet, muscle weakness, and history of a fibula fracture. Review of Resident #5's current care plan dated 09/10/22 revealed: -The resident ambulated with a walker and was oriented.	{D 273}		

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{D 273}	Continued From page 1 -The resident was independent in eating, toileting, ambulating and transferring and required supervision with bathing, dressing, and grooming. a. Review of Resident #5's current FL-2 dated 11/10/21, revealed there was an order for Tylenol 325mg, take 2 tablets every 6 hours as needed for mild pain. Review of Resident #5's physician orders dated 01/14/22, revealed there was an order for Tylenol 325mg, take 2 tablets every 6 hours as needed for mild pain. Review of Resident #5's Incident/Accident (I/A) report dated 05/26/22 revealed: -The resident stated she got tangled in a cord and fell on 05/26/22 at 10:00am. -The resident was sent to the hospital via ambulance and the primary care provider (PCP) and responsible party were notified. -There was no documentation of the resident's injuries. Review of Resident #5's hospital after visit summary report dated 05/26/22 revealed: -The resident was seen in the emergency room (ER) for a fall that resulted in an injury of the knee, ankle and foot. -There were instructions to take Tylenol every 4-6 hours as needed for pain and elevate the extremity to reduce bruising and swelling. -There was an order to schedule an appointment with the resident's PCP as soon as possible for a follow-up evaluation. Review of Resident #5's progress notes revealed: -On 06/01/22, the resident's knee continued to be bruised and swollen; she complained of pain and discomfort.	{D 273}		

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-On 06/02/22, the resident complained of discomfort from her swollen knee.
-On 06/03/22, the resident complained of leg swelling and discomfort, bruising was noted.
-On 06/04/22, the resident complained of left knee pain and it continued to be bruised and swollen.
-On 06/05/22, the resident's knee was observed to be swollen and bruised.
-On 06/06/22, the resident's knee was observed to be swollen and bruised.
-On 06/07/22, the resident's left knee was observed to remain swollen and bruised with complaints of pain.

Review of Resident #5's electronic medication administration record (eMAR) revealed:
-There was an entry for Tylenol 325mg, take 2 tablets every 6 hours as needed for mild pain.
-The Tylenol was documented as administered to the resident on 05/26/22 at 8:38pm, 05/27/22 at 3:57pm, 05/28/22 at 9:54am, 05/30/22 at 7:30pm, and 05/31/22 at 7:33pm.

Review of Resident #5's eMAR revealed:
-There was an entry for Tylenol 325mg, take 2 tablets every 6 hours as needed for mild pain.
-The Tylenol was documented as administered to the resident on 06/01/22 at 7:44pm, 06/02/22 at 7:38pm, 06/03/22 at 8:35am, 06/03/22 at 7:55pm, 06/04/22 at 9:23am, 06/04/22 at 7:37pm, 06/05/22 at 7:30pm, 06/06/22 at 7:22pm, and 06/07/22 at 7:56pm.

Observation of Resident #5 on 06/08/22 at 9:54am revealed:
-The resident was sitting in an armchair with her left leg elevated on an ottoman.
-Her left knee and ankle were swollen and bruised; the entire knee was slightly swollen, blue

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{D 273}	Continued From page 3	{D 273}		

and purple, her calf was reddened with multiple small bruises and scratches, and her ankle had swelling on the outer aspect the size of large apple that extended to the middle of her foot.
-There was a hospital bed in her room with halo bars and she had a walker nearby.

Interview with Resident #5 on 06/08/22 at 9:54am and 3:09pm revealed:
-She had fallen a little over a week ago when she tripped over a cord to her radiator unit while trying to walk to her dresser and landed on her knee and back.
-She had to yell and scream for someone to come help her because she could not get to her call bell.
-A staff member heard her and came to help.
-The staff stayed with her until an ambulance arrived and took her to the hospital.
-She missed her follow up appointment for the injury and she was not sure when it had been rescheduled, but thought it was supposed to be the previous day (06/07/22).
-She thought the follow up appointment had been rescheduled due to having a Covid-19 outbreak in the facility.

Observation of Resident #5 on 06/09/22 at 10:29am revealed:
-The resident was sitting in an armchair with her left leg elevated on an ottoman.
-Her left knee and ankle were swollen and bruised; the entire knee was slightly swollen, blue and purple, her calf was reddened with multiple small bruises and scratches, and her ankle had swelling on the outer aspect the size of large apple that extended to the middle of her foot.

Interview with Resident #5 on 06/09/22 at 10:29am revealed:

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{D 273}	Continued From page 4 -She had consistent pain in her left knee down to her ankle and foot from the time of the fall to current. -The first few days after the fall, her pain level was a 10 out of 10 (0 being no pain, to 10 being the worst pain she had felt), it has slowly decreased over the last weeks and was currently a 4 out of 10. -The staff had not consistently checked on her or asked her if she was in pain since the fall. -If she was in pain, she had to use her call bell to request Tylenol for the pain. -The Tylenol did not take her pain away, but it did help decrease it when it became too much and it when it wore off, the pain came back. -She had not been taking Tylenol regularly, only when she requested it due to the pain. -She had been elevating her leg because that was what the ER physician told her to do, not because the facility told her to do it. -The ER physician also recommended to follow up with her PCP as soon as possible but she was unsure what the status of her appointment was. -She had hoped she could have already seen her PCP because he might have given her some medications to help her heal more quickly and be more comfortable from the pain. -The pain has kept her from being able to walk and move around as she normally would. -She wished staff had checked in on her more frequently, especially in the beginning when the pain was so severe. Interview with a personal care aide (PCA) on 06/09/22 at 11:05am revealed: -Resident #5 fell on 05/26/22, she was not working that day, but knew the resident injured her knee when she fell and was transported to the hospital. -Resident #5 was normally very independent and	{D 273}		

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had been keeping her leg elevated because it was swollen and bruised.
-Resident #5 had complained of pain every day she had worked after the fall when she checked on the resident.
-She notified the medication aide (MA) who was responsible to follow up with the resident.
-The MA was responsible to offer the resident any pain medication and to notify the resident's PCP as needed.
-She was not sure who was responsible to make Resident #5's follow-up appointment.

Interview with a second PCA 06/09/22 at 11:18am revealed:
-Resident #5 fell on 05/26/22, she was not working that day, but knew the resident injured her knee which was still swollen and bruised.
-Since the fall the resident has required more assistance due to not being able to walk independently.
-The resident had complained of pain most days since her fall.
-The resident would use her call button, if the pain was really bad, to tell the staff she wanted pain medication.
-It was the MAs' responsibility to provide pain medication and to notify the resident's PCP as needed of changes.
-It was the MA's responsibility to make Resident #5's follow-up appointment.
-She was unsure why the resident had not been seen by her PCP yet.

Interview with the MA on 06/09/22 at 11:30am revealed:
-She was working when Resident #5 fell on 05/26/22.
-Since the fall, Resident #5 had sat in her recliner with her leg elevated and had complained of pain

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every day.
-Resident #5 used her call bell to call staff and request pain mediation when she wanted or needed it.
-She did not offer the resident any pain mediation around the clock because it was a PRN (as needed) order.
-The MAs' were responsible to give the transporter the hospital discharge paperwork so the transporter could make Resident #5's follow-up appointment.
-The follow-up appointment should have been made within the next business day.
-If the transporter was not available, the MAs should have made Resident #5's follow-up appointment.
-She was not sure why there was a delay in making Resident #5's follow-up appointment and assumed the transporter had made the appointment.
-She was not aware the resident had not been seen by her PCP yet.
-Resident #5's PCP could have assessed her and provided orders for instruction on how to care for her and control her pain.

Interview with the RCD on 06/09/22 at 11:58am revealed:
-She was working when Resident #5 fell on 05/26/22.
-The facility called 911 for an ambulance and the resident was sent to the hospital and she came back the same day with orders to follow up with the PCP.
-It was the transporter's responsibility to make Resident #5's PCP follow-up appointment within one business day of the resident's return.
-She was not sure why there was delay in making the resident's appointment with the PCP.
-She was not aware that the PCP was not aware

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{D 273}	Continued From page 7 of the resident's injuries. -The MAs should have reported the injuires to the PCP. -If the PCP had been aware of the resident's injuries, he could have provided orders to care for the resident and control her pain. -Having a delay in Resident #5's follow-up appointment could have resulted in complications from not being assessed without orders to guide her care. -She was not aware Resident #5 had been complaining of pain and expected the MAs to report the pain to the resident's PCP and check on the resident regularly to provide pain medication consistently as ordered to keep the resident comfortable around the clock. -She was not aware the resident had been in pain and would have called the PCP herself if she had known. Interview with the transporter on 06/09/22 at 12:25pm revealed: -It was MA's responsibility to give her the information needed to make resident appointments as soon as possible within one business day. -Her hours and days that she worked varied and she was not sure why there was a delay in calling to make the appointment until 06/01/22. -Resident #5's follow-up appointment should have been made on 05/27/22 and if she was off that day it would have been the MA's responsibility to call and make the appointment. Interview with the Executive Director (ED) on 06/09/22 at 12:48pm revealed: -She expected Resident #5's follow-up appointment from her fall on 05/26/22 to have been made within one business day of her return from the hospital on 05/27/22.	{D 273}		

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{D 273}	Continued From page 8 -She expected the MAs to notify Resident #5's PCP or the RCC of her pain until she could be assessed to obtain orders to guide her care. -She was not aware Resident #5's follow-up appointment had not been made. -She was not aware hhat the resident had been in pain without orders to guide her care and the PCP had not been notified. -She expected all facility staff to have checked on Resident #5 frequently and provide the resident comfort measures and pain medication regularly. Interview with Resident #5's PCP's Clinical Nurse Supervisor on 06/09/22 at 8:40am and 9:38am revealed: -The facility notified the PCP's office that the resident fell and went to the ER on 05/26/22, but the facility did not notify the PCP's office of any injury or emergent need for the resident to follow up. -The facility requested a PCP appointment for the resident on 06/01/22 and it was scheduled for 06/02/22, but the facility canceled it and there had been no attempt to reschedule the appointment. -The facility was expected to call as soon as possible after the injury per the ER discharge summary to have the resident follow up with the PCP. -The PCP office was open on 05/27/22 and 05/31/22 despite the Memorial Day holiday and the facility could have called on 05/27/22 to have the resident seen as ordered. -It was important for the resident's injuries and pain to be assessed for further imaging to rule out fractures and to ensure proper healing of the injury and pain control. -Two weeks was too long for the resident to have gone without assessment and treatment after her injury. -Even if there had been a Covid-19 outbreak in	{D 273}		

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the facility, the PCP office still would have seen the resident in person if she was asymptomatic.
-If she did have Covid-19 symptoms, the PCP office could have offered the resident a virtual telehealth appointment to prevent a delay in her care.
-There was no excuse she had not yet been seen and assessed by the PCP.

b. Review of Resident #5's current FL-2 dated 11/10/21 revealed and order to check blood pressure daily and notify the PCP of a systolic blood pressure (SBP - top number) greater than 130 or less than 100 and a diastolic blood pressure (DBP - bottom number) greater than 90 or less than 50.

Review of Resident #5's current physician orders dated 01/14/22 revealed:
-There was an order to check blood pressure daily and notify the PCP of a SBP greater than 130 or less than 100 and a diastolic blood pressure DBP greater than 90 or less than 50.

Review of Resident #5's hospital after visit summary report dated 05/26/22 revealed:
-The resident was seen in the emergency room (ER) for a fall and elevated blood pressure.
-There were instructions to follow up with the PCP as soon as possible.

Review of Resident #5's current licensed health professional support (LHPS) evaluation dated 02/10/22 revealed the resident had elevated blood pressures at times.

Review of Resident #5's April 2022 electronic medication administration record (eMAR) revealed:
-There was an entry to check blood pressures

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{D 273}	Continued From page 10 daily and notify the PCP of a SBP greater than 130 or less than 100 and DBP great than 90 or less than 50. -On 04/15/22, her blood pressure (BP) was documented as 166/92. -On 04/16/22, her BP was documented as 97/48. -On 04/18/22, her BP was documented as 147/44. -On 04/19/22, her BP was documented as 134/83. -On 04/20/22, her BP was documented as 182/86. -On 04/25/22, her BP was documented as 144/71. -On 04/28/22, her BP was documented as 140/81. -There was no documentation the PCP was notified of BPs outside of parameters. Review of Resident #5's May 2022 eMAR revealed: -There was an entry to check blood pressures daily and notify the PCP of a SBP greater than 130 or less than 100 and DBP great than 90 or less than 50. -On 05/08/22, her BP was documented as 131/62. -On 05/09/22, her BP was documented as 131/81. -On 05/11/22, her BP was documented as 145/68. -On 05/14/22, her BP was documented as 170/74. -On 05/16/22, her BP was documented as 132/84. -On 05/17/22, her BP was documented as 131/69. -On 05/18/22, her BP was documented as 140/69. -On 05/19/22, her BP) was documented as 97/56.	{D 273}		

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-On 05/24/22, her BP was documented as 144/71.
-On 05/25/22, her BP was documented as 141/74.
-On 05/27/22, her BP was documented as 139/61.
-On 05/29/22, her BP was documented as 137/80.
-On 05/31/22, her BP was documented as 132/74.
-There was no documentation the PCP was notified of BPs outside of parameters.

Review of Resident #5's June 2022 eMAR revealed:
-There was an entry to check blood pressures daily and notify the PCP of a SBP greater than 130 or less than 100 and DBP great than 90 or less than 50.
-On 06/01/22, her BP was documented as 132/76.
-On 06/02/22, her BP was documented as 138/72.
-On 06/03/22, her BP was documented as 142/65.
-On 06/04/22, her BP was documented as 132/64.
-On 06/05/22, her BP was documented as 132/64.
-On 06/06/22, her BP was documented as 132/68.
-There was no documentation the PCP was notified of BPs outside of parameters.

Interview with Resident #5 on 06/09/22 at 10:29am revealed:
-Her doctor ordered her blood pressures to be monitored every day because she had a history of unstable blood pressures that were up and down.
-She was not sure what her doctor was looking

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{D 273}	Continued From page 12 for, but it had been a long-standing condition for her. Interview with a medication aide (MA) on 06/09/22 at 11:30am revealed: -The MA's were responsible to obtain Resident #5's blood pressures daily, document them in the resident's eMAR, then notify the resident's PCP of any values outside of parameter via fax and document the notification in the resident's progress notes. -The MA's were then responsible to give the fax to the Resident Care Director (RCD) for review and follow-up. -She was not sure why Resident #5's blood pressures outside of parameters had not been reported to her PCP except that it likely got missed because staff were so busy. -She had personally gotten busy and overlooked reporting the resident's BPs outside of parameters to the PCP. -MA's were expected to follow orders accurately as written by the provider for resident care and safety. -It was important for staff to report blood pressures outside of parameters consistently so Resident #5's PCP would be aware of an issue in which he might want to change her orders for treatment and monitoring. Interview with the RCD on 06/09/22 at 11:58am revealed: -MA's were responsible to obtain resident's blood pressures, assess parameters, and report any values outside of parameters to her and the PCP via fax, then document the notification in the resident's progress notes. -She was not aware Resident #5 was having blood pressures outside of parameters and that the PCP had not been notified as ordered.	{D 273}		

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-MAs were expected to follow orders accurately as written.
-It was important to notify resident's PCP of blood pressures outside of parameters as ordered for resident safety and care.
-There was no process in place at that time to audit resident records or eMARs because she had just started and had not had time.

Interview with the Executive Director (ED) on 06/09/22 at 12:48pm revealed:
-She expected MAs to follow orders accurately as written and report BPs outside of parameters immediately via fax to the PCP and verbally to the RCD with documentation in the resident progress notes.
-Not reporting BPs outside of ordered parameters could lead to adverse medical issues for residents or complications affecting resident safety.
-Resident providers wrote orders for BPs with parameters for a reason to guide resident care and safety.
-There was no process in place to audit resident records because she and the RCD were both new to their positions and they had not implemented audits yet.

Interview with Resident #5's PCP's Clinical Nurse Supervisor on 06/09/22 at 8:40am revealed:
-There was no documentation that the resident's PCP had been notified of her blood pressures outside of parameters for 04/15/22 - 04/28/22, 05/08/22 - 05/31/22, and 06/01/22 - 06/06/22.
-Resident #5's PCP wanted to be notified of the resident's blood pressures outside of parameters because the resident had a history of hypertension and he wanted to monitor her values to adjust her medications as needed.
-Resident #5's PCP expected the facility to call or

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fax the PCP's office on the same day the of the blood pressure checks were outside of parameters as ordered.
-The facility had not consistently reported the resident's blood pressures outside of parameters since August 2021 and she was not sure why.

2. Review of Resident #3's current FL-2 dated 02/21/22 revealed:
-Diagnoses included diabetes mellitus (DM) (a condition that causes high blood sugars).
-There was an order for Lantus insulin, give 50 units daily before bed (long acting insulin used to control and lower high blood sugars).
-There was an order to check finger stick blood sugars (FSBS) before breakfast and before bedtime and to notify the primary care provider (PCP) of any FSBS greater than 300.

Review of Resident #3's Resident Register revealed:
-The resident was admitted to the facility from home on 02/23/22.
-The resident required assistance scheduling appointments.

Review of Resident #3's current physician orders dated 03/08/22 revealed:
-There was an order to check FSBS before breakfast and before bedtime and to notify the PCP of any FSBS greater than 300.
-There was an order for Lantus insulin, give 50 units daily before bed.

Review of Resident #'3's current care plan dated 03/08/22 revealed the resident had diabetes and her FSBS were to be checked twice daily and she was insulin dependent.

a. Review of Resident #3's progress notes

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revealed:
-On 05/29/22, it was documented that the resident was not feeling well with a temperature of 99 degrees.
-On 06/01/22, it was documented that the resident tested positive for Covid-19.

Review Resident #3's Resident Physician Form dated 06/02/22 revealed there was a note faxed to the primary care provider to notify him the resident had tested positive for Covid-19 on 06/01/22.

Review of Resident #3's physician's order form dated 05/31/22 revealed:
-The facility requested a prescription for Robitussin Maximum (cold medicine) for cold symptoms.
-The PCP signed an order for Robitussin Maximum, 1 teaspoon by mouth as needed every 4 hours on 06/02/22.

Review of Resident #3's future appointment form revealed the resident was to have an appointment with her PCP on 06/08/22 at 3:20pm.

Review of Resident #3's standing physician orders dated 02/21/22 revealed there was an order to notify the PCP if the resident had diarrhea for greater than 24 hours.

Observation of Resident #3 on 06/08/22 at 10:04am revealed she was lying in bed and appeared weak and lethargic.

Interview with Resident #3 on 06/08/22 at 10:04am revealed:
-She was recently diagnosed with Covid-19 and was improving but was still not feeling well with

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symptoms of being tired, nausea, vomiting, and diarrhea.
-She was out of breath when trying to speak.
-She was supposed to see her primary care provider (PCP) that day to follow up.

Interview with Resident #3 on 06/09/22 at 10:53am revealed:
-She started feeling bad about a week ago with flu like symptoms and tested positive for Covid-19 on 06/01/22.
-She reported her symptoms of nausea, vomiting, and diarrhea to facility staff multiple times but could not remember who she told and on what days.
-Within 1-2 days of beginning to feel bad, she began to skip meals because she threw up or had diarrhea.
-She had not eaten many meals since she was diagnosed with Covid-19 and the staff were aware of it because she told them she did not want anything to eat.
-She felt too bad and was too tired to eat but would try to snack a little when she could.
-The staff had assisted her when she was throwing up, but no one had offered her any medications to help her feel better.
-She received an anti-diarrheal medication and Tylenol when she requested it from staff a couple of times but could not recall when.
-She was supposed to follow-up with her PCP yesterday (06/08/22) but she did not feel well so she did not go because she was sick and throwing up.
-She was not sure what her FSBS had been and she had continued to receive her insulin as normal even though she had not been eating much.

Interview with a personal care aide (PCA) on

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{D 273}	Continued From page 17 06/09/22 at 11:05am revealed: -She had assisted Resident #5 out of the dining on the previous day (06/08/22) because she had not been feeling well and the resident vomited when she got back to her room. -Resident #5 started feeling bad about one week ago when she was diagnosed with Covid-19 and was feeling bad yesterday (06/08/22) with the nausea and vomiting. -She checked on the resident every two hours when she worked and asked her how she was doing, but she did not recall the resident complaining of nausea, vomiting, or diarrhea prior to yesterday (06/08/22). -Resident #5 normally ate well at all three meals every day in the dining room. -The resident was served in her room while on quarantine but started skipping meals when she was diagnosed with Covid-19. -She could not recall if she had reported Resident #5's symptoms to anyone else, but other staff were aware. Interview with the MA on 06/09/22 at 11:30am revealed: -She was unsure when Resident #3 began feeling ill with Covid-19 and had only been made aware the resident had been experiencing nausea, vomiting, and diarrhea yesterday (06/08/22). -The resident reported to her yesterday that she was having loose stools, but she had not been aware that the resident had not been eating and skipping meals. -It was all facility staff's responsibility to communicate and ensure residents were eating and to report if a resident was not eating appropriately or normally so it could be reported to the resident's PCP for guidance and care. -If she had been made aware that Resident #5 was not eating and feeling worse, it would have	{D 273}		

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been her responsibility to report the symptoms to the PCP and the Resident Care Director (RCD).
-She was not sure who the resident reported her symptoms to.

Interview with the RCD on 06/09/22 at 11:58am revealed:
-Resident #3 tested positive for Covid-19 on 06/01/22 with flu-like symptoms, but she was not sure when the resident began experiencing nausea, vomiting, or diarrhea.
-She was also not aware that Resident #3 had been skipping meals and not eating as normal.
-The PCAs and MAs were responsible to report the resident's change in condition of nausea, vomiting, diarrhea, and lack of eating to her and the MA's were responsible to report the issue to the resident's PCP to obtain guidance for the resident's care.
-It was important for staff to communicate and report issues to resident's PCP because Resident #5's symptoms could have led to dehydration and decreased FSBS since the resident had diabetes.
-If the MAs or PCAs had made her aware, she would have notified Resident #3's PCP for further guidance.

Interview with the Executive Director (ED) on 06/09/22 at 12:48pm revealed:
-She was not aware that Resident #3 developed nausea, vomiting, diarrhea, and began skipping meals after being diagnosed with Covid-19 on 06/01/22.
-Resident #3 had diabetes and all facility staff were responsible to communicate any concerns the resident was having so the MA or the RCD could report the change in status to the resident's PCP for guidance in care and orders.
-It was important to report and address Resident #3's symptoms to avoid adverse outcomes such

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as decreased FSBS, dehydration, passing out, and weakness for the resident's safety.

Interview with Resident #3's PCP on 06/09/22 at 9:22am revealed:
-He was made aware that the resident tested positive for Covid-19 on 06/01/22, but he was not made aware she was experiencing nausea, vomiting, diarrhea, and skipping meals.
-He expected to be notified of any symptoms or complications the resident may be having immediately to provide orders to guide her care and make her comfortable.
-It was concerning that the resident was having on-going adverse symptoms and skipping meals because she had diabetes and if she was not eating with those symptoms she could become dehydrated and her FSBS sugars could drop too low since if she continued to get her insulin.
-He had recently decreased her dose of insulin due to her having issues with low blood sugars.
-If he had been made aware of her symptoms and lack of eating, he would have provided orders for medications, and to monitor her FSBS more frequently and hold her insulin until the issues resolved.
-The resident was supposed to have had an appointment yesterday (06/08/22) but the facility had canceled it.
-The resident should have come in to his office for her appointment that day to be assessed since she was not feeling well.
-The appointment should not have been cancelled because he could have seen her virtually due to the Covid-19.
-If the resident had refused to come to the appointment, the facility could have called him for guidance and telephone orders.
-The resident could have been transported to the emergency room if her symptoms worsened.

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{D 273}	Continued From page 20 b. Review of Resident #3's May 2022 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS before breakfast and before bedtime and to notify the PCP of any FSBS greater than 300. -The resident's FSBS was documented as 302 on 05/14/22. -The resident's FSBS was documented as 323 on 05/26/22. -There was no documentation that the FSBS outside parameters to the PCP. Interview with the MA on 06/09/22 at 11:30am revealed: -It was the MA's responsibility to obtain FSBS and report any values outside of ordered parameters to the resident's PCP via fax, then document the notification in the resident's progress notes immediately. -The fax was then given to the Resident Care Director (RCD) for follow up and review. -It was important for resident's PCP to be aware of FSBS outside of parameters so they can assess the resident and review the results to provide orders or changes medications as needed. -Facility staff were expected to follow orders accurately as written to provide safe care to residents. Interview with the RCD on 06/09/22 at 11:58am revealed: -MA's were responsible to obtain resident's FSBS, assess parameters, and report any values outside of parameters to her and the PCP via fax, then document the notification in the resident's progress notes. -She was not aware Resident #5 was having	{D 273}		

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{D 273}	Continued From page 21 FSBS outside of parameters and that the PCP had not been notified as ordered. -MAs were expected to follow orders accurately as written. -It was important to notify resident's PCP of FSBS outside of parameters as ordered for resident safety and care. -If she had been made aware of the FSBS outside of parameters, she would have notifed the resident's PCP herself. Interview with the Executive Director (ED) on 06/09/22 at 12:48pm revealed: -She expected MAs to adhere to orders accurately as written and report values outside of parameters immediately via fax to the PCP and verbally to the RCD with documentation in the resident progress notes. -Not reporting values outside of ordered parameters could lead to adverse medical issues for residents or complications affecting resident safety. -Resident's medical providers wrote orders with parameters for a reason to guide resident care and safety. -There was no process in place to audit resident records because she and the RCD were both new to their positions and they had not implemented audits yet. Interview with Resident #3's PCP's nurse on 06/09/22 at 9:05am revealed: -The resident's PCP was not notified of her FSBS greater than 300 on 05/14/22 or 05/26/22 as ordered. -The PCP expected to be notified of FSBS outside of parameters as ordered so he could monitor her trends and adjust her insulin as needed.	{D 273}		

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{D 273}	Continued From page 22 Interview with Resident #3's PCP on 06/09/22 at 9:22am revealed: -He expected the facility to follow his orders as written and notify him of FSBSs outside of parameters as soon as possible so he could provide orders as needed. -Resident #3 had a history of taking her medications irregularly prior to admission to the facility and her FSBS were unstable. -Now that she was receiving her medications as ordered on a regular basis at the facility, it was important for him to monitor her blood sugars closely to adjust her insulin as needed. -Having consistent increased FSBS greater than 300 could lead to long-term adverse health outcomes or hospitalizations. _____ The facility failed to provide referral and follow up and primary care provider (PCP) notification for Resident #5 in which she fell and injured her left knee and ankle requiring assessment at the emergency department (ED) and a follow up with her PCP as soon as possible which had not taken place 14 days post fall and injury and the resident had pain that ranged from mild to severe with swelling and bruising of the extremity. The facility also failed to notify the PCP of Resident #3's change in condition in which experienced nausea, vomiting, and diarrhea after being diagnosed with Covid-19 in which she was unable to eat as normal and had a diagnosis of diabetes in which her blood sugars could have dropped too low. 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 protection in accordance with G.S. 131D-34 o 06/09/22 for this violation.	{D 273}		

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{D 273}	Continued From page 23 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 7, 2022.	{D 273}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to Health Care. The findings are: Based on observations, interviews, and record reviews, the facility failed to notfy the primary care provider (PCP) notification for 2 of 5 sampled residents (#3 and #5) in which a resident was injured from a fall and required a follow-up appointment (#5), a resident had a change in condition (#3), and for finger stick blood sugars (#3) and blood pressures (#5) that were outside of ordered parameters. [Refer to Tag 273, 10A NCAC 13F .0902 (b) Health Care (Type B Violation)].	{D912}		